MARKET CONDUCT REPORT ON EXAMINATION

OF THE

UNITED HEALTHCARE INSURANCE COMPANY OF NEW YORK, INC.

UNITED HEALTHCARE OF NEW YORK, INC.

AND

UNITED HEALTHCARE OF UPSTATE NEW YORK, INC.

AS OF

DECEMBER 31, 1999

DATE OF REPORT	JANUARY 22, 2001
EXAMINER	BRUCE E. BOROFSKY

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STATE OF NEW YORK
INSURANCE DEPARTMENT
25 BEAVER STREET
NEW YORK, NEW YORK 10004

January 22, 2001

Honorable Neil Levin
Superintendent of Insurance
Albany, New York 12257

Sir:

Pursuant to the provisions of the New York Insurance Law and acting in accordance with directions contained in Appointment Numbers 021359, 021360 and 021361, each dated February 16, 1999 and annexed hereto, I have made an examination into the condition and affairs of three domestic United HealthCare Companies. These entities are as follows:

- United HealthCare Insurance Company of New York, Inc., an accident and health insurer licensed under Article 42 of the New York Insurance Law;
- United HealthCare of New York, Inc, a health maintenance organization licensed under Article 44 of the New York Public Health Law; and
- United HealthCare of Upstate New York, Inc., a health maintenance organization licensed under Article 44 of the New York Public Health Law.

The following report as respectfully submitted deals with the manner in which the United HealthCare Companies conduct their business practices and fulfill their contractual obligations to policyholders and claimants.

Reports dealing with matters pertinent to the financial condition of the New York United HealthCare Companies will be issued under separate cover.

Whenever the terms "the Company", "UHC" or "United HealthCare" appear herein without qualification, they should be understood to mean the New York United HealthCare Companies.

Whenever the term "Insurance Company" appears herein without qualification, it should be understood to mean United HealthCare Insurance Company of New York, Inc.

Whenever the terms "Upstate HMO" and "Upstate Plan" appear herein without qualification, they should be understood to mean United HealthCare of Upstate New York, Inc.

Whenever the terms "Downstate HMO" and "Downstate Plan" appear herein without qualification, they should be understood to mean United HealthCare of New York, Inc.

Whenever the term "the Plans" appears herein without qualification, it should be understood to mean both United HealthCare of New York, Inc. and United HealthCare of Upstate New York, Inc.

1. SCOPE OF EXAMINATION

As part of the Department's examination of United HealthCare, a review of the manner in which United HealthCare conducts its business practices and fulfills its contractual obligations to policyholders and claimants has been performed. This review contains significant findings and covers transactions occurring through December 31, 1999.

The purpose of this report is to assist United HealthCare's management in addressing problems that are of such a nature that corrective action is required. Accordingly, this report is confined to comments on those matters that involve departures from laws, regulations or rules, or which are deemed to require an explanation or description.

2. MANAGEMENT

During May 1999, the Department issued Circular Letter No. 9 on the subject "Adoption of Procedure Manuals." The letter states that it is critical that the board of directors of each Article 44 Health Maintenance Organization and insurer licensed to write health insurance adopt specified procedures to ensure that all claims are being processed accurately, uniformly, and in accordance with applicable statutes, rules, and regulations. The letter also recommended the following:

> "that the board obtain the following certifications annually: (i) from either the company's director of internal audit or independent CPA that the responsible officers have implemented the procedures adopted by the board, and (ii) from the company's general counsel a statement that the company's current claims adjudication procedures, including those set forth in the current claims manual, are in accordance with applicable statutes, rules and regulations."

Finally, the letter requested confirmation that Circular Letter No. 9 would be distributed to all board members and, if applicable, to the board members of the parent corporation prior to the respective board's next regularly scheduled meeting. Such distribution, receipt and any subsequent discussion should have been recorded in the minutes of the respective board's meeting.

Examination of the board minutes for all three NY United HealthCare entities revealed that the recommended discussions did not take place. Further, an annual certification recommended by the Circular Letter was not obtained for calendar year 1999. When asked why these measures had not been adopted, the examiners were advised the Company believed the Circular Letter was only advisory in nature and thus, not obligatory on the Company. The Company also indicated that it believed that its ongoing efforts and more recently proposed action plans to correct any deficiencies and to ensure adequate claim handling were in keeping with the principles outlined in the letter.

It was the intent of the Circular Letter to remind companies that it was ultimately the board of directors who oversee management's handling of the claims adjudication process. As such, the processes described serve to further the Department's goal of enhancing regulatory compliance.

It is recommended that the Company implement the notification and certification requirements of Circular Letter No. 9 (1999).

Subsequent to the finding, the Company was able to show that it complied with this recommendation.

One of the online systems (the Preference System) that was being used by claim processors to determine New York mandates did not contain several recent initiatives, including prompt pay and community rating. The system in question also contained standards that had expired or been changed. Examples include emergency room procedures, and mandates regarding pregnancy and pre-existing conditions, among others. When this was pointed out to the Company, the examiners were advised that the Preference System was being phased out in favor of an Intranet process. The examiner expressed concern that the existence of conflicting information can serve to confuse the issues. Such conflicting information also runs counter to the Department's Circular Letter No. 9 (1999). The Company contended that in the future it would be able to demonstrate that its Intranet based system would follow the guidance contained in the Circular Letter.

It is recommended that the Company comply with Circular Letter No. 9 (1999) and update all processing guidelines, regardless of format, to ensure they are consistent and in compliance with New York's mandates on health care.

Any violations resulting from lack of clear guidance on New York statute or regulation are detailed later herein under the appropriate section of the report.

3. SALES/UNDERWRITING

A. Open Enrollment

Prospective direct pay subscribers can obtain a telephone number to get information on enrollment with United HealthCare through the Company website, through advertisements and through the Insurance Department. Contact with those sources, however, provides a telephone number that has a toll charge. Once the toll number is dialed, interested consumers must answer a series of voice mail prompts before they are given a different, but toll-free phone number to call. When the toll-free telephone number is dialed, consumers are given seven voice mail options to choose from. None of the options offered pertains to enrollment information.

Pursuant to New York Insurance Law §4321(a), United HealthCare has an obligation to provide health insurance to eligible consumers who seek to purchase it. The informational procedures it has implemented, however, work against the Company's ability to fulfill that obligation.

For this reason, it is recommended that the Company provide its toll-free telephone number to potential subscribers in its advertising medium. Further, the toll-free telephone number should include enrollment information as a voice mail option.

During testing of the phone line, the examiners were advised on two occasions that small group coverage is considered to be five or more employees. This is inaccurate information and is thus misleading in that §4317 of the New York Insurance Law defines a small group as between two and fifty employees.

During June 1998, the Company issued an alert marked "Urgent" to its agents and brokers indicating the Company would not cover groups with two lives who are husband and wife even if both are employees on a quarterly wage and tax statement. United HealthCare does cover other employer groups where the members are not husband and wife. This practice rendered the Company's denial of group coverage in the situation a violation of New York Insurance Law §4317.

It is recommended that the Company comply with §4317 of the New York Insurance Law and offer small group policies to groups of between two and fifty, regardless of marital status.

B. Underwriting

At the time of the examination, the Company was utilizing a "New Member Letter" that was in violation of §4318(a) and (b) of the New York Insurance Law, "Pre-

existing Condition Provisions." Subsection (a) of the law states that an enrollee is considered to have maintained continuous coverage for pre-existing condition purposes if they have not had a gap of more than 63 days between the termination of their previous coverage and the enrollment date of their new coverage. Subsection (b) of the law defines enrollment date as the date the enrollee files a substantially complete application for coverage.

The "New Member Letter" in question stated that there were two dates during each month when new members could be enrolled; the 1st and the 15th. In order to be enrolled on the closest effective date, the enrollee had to submit his or her application more than five days prior to that date. If the enrollee submitted his/her application in less than five days, they were required to wait until the following enrollment date. This meant that potentially, an enrollee had to wait as many as 20 days before their coverage began.

The letter goes on to indicate that the Company counts the 63-day limit from the termination of the old coverage to the *effective* date of the new coverage. The effect of this rule is that an enrollee must submit their application as many as 20 days prior to their effective date in order to maintain coverage under the pre-existing coverage rules, thus effectively shortening the 63-day limit to as little as 41 days. This penalizes the subscriber in violation of New York law.

It is recommended that the revised New Member Letter use the application date and not the effective date, for the purpose of calculating continuing coverage as required by New York Insurance Law §4318(a) and (b).

It is recommended that the Company determine how the document that was violative of New York Insurance Law §4318 was originally approved for distribution in order to prevent a reoccurrence.

After this violation was brought to the Company's attention, they discontinued use of the letter and formed a Compliance Department with a dedicated compliance manager to oversee and monitor health plan compliance with state regulations.

C. Premium Rates of Community-Rated Contracts

New York Insurance Law §4308(b) sets forth the standard for the filing and approval of community rates. As an alternate, under §4308(g), the Company may use rates filed with the Superintendent without his prior approval under certain circumstances. A review of the Company's underwriting activities revealed that they were not in compliance with the provisions of §4308. Specifically, seven percent, or five, of the 75 HMO groups tested were not being charged the rate that had been approved by the Department. The Company found thirty-seven additional enrolled groups that were being charged incorrect rates after the examiners requested that a further search be made on the population as a whole using the parameters of the errors that were located in the sample.

The causes of the errors were as follows:

- One group was billed the rate for a different United HealthCare entity.
- Two groups were charged incorrect rates because of system constraints. Specifically, an override that was required to overcome the fact that only one set of tier relationships are allowed within the system was not applied. Thus, the wrong tier price was used.
- Two groups were billed at the wrong quarterly rate for two separate reasons. In one instance, the proper rate had not yet been installed in the system. In the second instance, the proper rate was inappropriately overridden.
- Most of the remaining differences were due to variations in rounding.

It is recommended that the Company take steps to ensure that rates charged are approved and properly billed as required by New York Insurance Law §4308(b).

The HMO Plus product is a Point of Service ("POS") coverage plan containing both, in-network coverage, and out-of-network coverage. For this product, the HMO covers in-plan visits while the Insurance Company covers out-of-plan visits.

For the HMO Plus product, United HealthCare experience rates groups of 50+ employees using the total experience of the group. The overall rate is compared to the filed large group community rate for the HMO portion of the contract to ensure that the

total POS product rate is higher than the filed large group community rate for the HMO portion of the contract. If needed, the total POS product rate is adjusted upward to make the total at least 5% higher than the filed HMO large group community rate. The use of this methodology to determine the rate appears to be in violation of New York Insurance Law §4308(b) in that the experience rating formula approved by the Department is being applied to the entire contract, but is only approved for use on the out-of-network portion of the policy that is written by United Health Insurance Company of New York.

New York Insurance Law §4308(b) states the following:

> "No corporation subject to the provisions of this article shall enter into any contract unless and until it shall have filed with the superintendent a schedule of the premiums, or if appropriate, rating formula from which premiums are determined, to be paid under the contracts and shall have obtained the superintendent's approval thereof."

It is recommended that the Company comply with New York Insurance Law §4308(b) and utilize an experience-rating formula that has been approved by the Department.

D. Agent and Broker Licenses

§2116 of the New York Insurance Law states:

> "No insurer authorized to do business in this state, and no officer, agent or other representative thereof, shall pay any money or give any other thing of value to any person, firm, association or corporation for or because of his or its acting in this state as an insurance broker, unless such person, firm, association or corporation is authorized so to act by virtue of a license issued or renewed pursuant to the provisions of section two thousand one hundred four of this article."

The examiners sampled 40 of UHC's 8,500 external producers. UHC was not able to provide copies of licenses for eight percent or three of these individuals. Another 20%, or eight, of the producers had expired licenses on file. While the Department's Consumer Services Bureau was able to confirm the producers within the sample did have current licenses, the Company needs to monitor the licenses to ensure it does not violate the law.

It is recommended that the Companies maintain current licenses on file for all of their active producers to ensure continued compliance with §2116 of the New York Insurance Law.

Subsequent to the finding, the Company was able to demonstrate that it had initiated steps to ensure that it maintained current licenses of all of its producers.

United HealthCare uses two types of external agents. The first type of external agents it uses are individual agents. The second type it utilizes are general agents or agencies that consist of multiple salespersons. General agents represent the Downstate HMO and the Insurance Company in the sale of small group medical insurance. The relationship to each of these entities is that of an independent contractor in that the general agents are only paid for the business they produce. Currently, the Company utilizes a written agreement between itself and its general agents to clearly spell out the rights and responsibilities of the agency. This practice serves to protect the Company in its relationship with the general agents. It is noted, however, that there are no such

written agreements between the general agents and the Upstate HMO. Additionally, there are no such agreements between any of the United HealthCare companies and the individual agents. As the agreement serves to protect the Company in its relationship with agencies, so would it protect it in its relationship with the individual agents.

It is recommended that the Company initiate a written agreement with its individual producers. Additionally, it is recommended that the Upstate Plan formalize an agreement with its general agents.

§2114(a)(3) of the New York Insurance Law states:

> "No insurer, fraternal benefit society or health maintenance organization doing business in this state and no agent or other representative thereof shall pay any commission or other compensation to any person, firm, association or corporation for services in soliciting or procuring in this state any new contract of accident or health insurance or any new health maintenance organization contract, except to a licensed accident and health insurance agent of such insurer, such society or health maintenance organization, or to a licensed insurance broker of this state, and except to a person described in paragraph two or three of subsection (a) of section two thousand one hundred one of this article."

This section requires United HealthCare employees to have licenses if they will be soliciting business and earn income on a commission basis. UHC utilizes approximately 76 such salaried employees. All licenses for these individuals were requested for testing by the examiners. UHC was not able to fulfill 71% of the license requests. Nor was the Department's Consumer Services Bureau able to confirm such licenses exist. The use of unlicensed agents is a violation of NY Insurance Law §2114(a)(3).

It is recommended that United HealthCare license its internal agents to confirm compliance with NY Insurance Law §2114(a)(3).

E Appointment of Insurance Agents with the Department

§2112(a) of the New York Insurance Law states:

> "Every insurer, fraternal benefit society or health maintenance organization doing business in this state shall file a certificate of appointment in such form as the superintendent may prescribe in order to appoint insurance agents to represent such insurer, fraternal benefit society or health maintenance organization."

Each of the Companies is required under NY Insurance Law §2112(a) to file certificates of appointment for their agents. The examiners requested that the United HealthCare companies provide a sample of 30 appointment letters from the Company's list of appointed agents. The Company was not able to produce 20%, or six letters of that sample. In addition, none of the agents utilized by United HealthCare of Upstate New York, Inc. were appointed to that entity.

It is recommended that United HealthCare of Upstate New York, Inc., file certificates of appointment for each of its agents as required by New York Insurance Law §2112(a).

The examiners then checked the list of appointments as provided by the Department against the list provided by the Company. A total of 17% of the appointed agents, as noted on the Department's list, were not on the lists provided by the Insurance

Company or the Downstate HMO. In other words, there appeared to be agents appointed by the Company that they are not aware of. This would seem to imply poor record keeping on the part of the Company.

It is recommended that the United HealthCare Companies improve their record keeping as regards agents and brokers.

4. CLAIM PROCESSING

A. Electronic Data Interchange

United HealthCare encourages its providers to submit claims electronically, instead of through the US mail. The process used to do this is referred to as Electronic Data Interface ("EDI"). The company's goal is to have 65% of all claims received in this manner.

The way electronically submitted claims enter the system is through EDI intermediaries. The EDI claims are received by the intermediaries who then proof the claims before sending them on to United HealthCare. Claims that are not complete are rejected and returned to the sender.

The EDI companies have a contractual obligation to submit 99% of the claims they receive within 24 hours of receipt.

This standard is monitored through visits by United HealthCare to the intermediaries. Additionally, United HealthCare monitors the rates of claims submissions to ensure consistency. There are, however, no computerized statistical analyses of the submission rates. In this regard, there was insufficient monitoring of the EDI companies.

United HealthCare indicates that an independent auditor will be auditing certain of the EDI companies for compliance with the claim submission standards and it is recommended they do so.

B. Schedule H Reporting

A review of United HealthCare's filed Schedule H (Aging Analysis of Unpaid Claims) was performed. This review evidenced United HealthCare's inability to adequately ascertain the aging of its unpaid claims.

Schedule H, which is a quarterly report, is used to report claims that have been received by the company, but are not yet paid.

Contrary to Department instructions, United HealthCare did not utilize actual claim inventory to complete Schedule H. Instead, the Company completed the form utilizing two sources; for accounting purposes, the sources of confirmation were claims

that were adjudicated and awaiting payment, and an estimate of the inventory and value of claims within the system that were not yet adjudicated.

The Company had stated that it was difficult, if not impossible, to determine the New York entities' Schedule H inventory because of the nature of the Company's processing systems. Those systems do not determine the entity to which a subscriber belongs until the claim is adjudicated.

When the Department advised the Company that the system they were using to complete Schedule H was inadequate, the Company submitted a plan that it maintained would allow it to obtain an estimate of the open claim population as required by Schedule H. The Department accepted the plan and for First Quarter 1999, the Company used the new methodology as agreed.

During the second quarter of 1999, however, both the Upstate HMO and the Downstate HMO failed to utilize the new plan. Instead, both entities utilized the previous method, making the Schedule H numbers not valid for that quarter. When this was pointed out to the Company, the systems and accounting error was acknowledged, and an amended Schedule H was immediately filed.

The Company's inability to determine the exact count and value of HMO claims awaiting adjudication appears to be a violation of 10 NYCRR Part 98.11. This NY Health Department rule requires that the HMO function be clearly distinguished from any

other functions through the maintenance of separate records, reports and accounts for the HMO function. Further, this points to the Company's apparent inability to comply with New York Insurance Law §308, which mandates that the Company reply to a request by the Superintendent for a special report.

The underlying theory behind the Department's promulgation of Schedule H was to have health care companies accurately report and age their claims, so that a measure of claim processing efficiency could be readily obtained. As long as the Companies' Schedule H filings do not report exact counts, such a measure is not possible.

It is recommended that the Company develop a system that will permit it to determine the exact count and inventory of NY claims at any given point in time as required by the Department and in the case of the two HMOs as required by 10 NYCRR Part 98.11(a).

It is recommended that the Company utilize its approved plan on a consistent basis or otherwise accurately report claim counts and values in its Schedule H filings in compliance with New York Insurance Law §308.

C. Emergent Care

Sections 3216(i), 3221(k)(4) and 4303(a)(2) of the New York State Insurance Law require that health insurance contracts include a provision permitting emergency room treatment using a prudent lay person standard. During the examination period,

United HealthCare utilized a list of sixteen emergency room diagnoses that it deemed not eligible for emergent care. Several of these diagnoses, including pharyngitis (sore throat), menstrual disorder, and strep throat, do fit within the prudent lay person standard of emergency care and should be considered eligible for emergent care. Other diagnoses on the list, (backache, headache) indicate the ailment will be covered if it is treated with intravenous medication upon arrival at the emergency room. Clearly, an insured cannot know prior to the emergency room visit what treatment will be used. As such, this standard is unreasonable. These processing procedures appear to be a violation of New York Insurance Law §2601(a), which states in part:

> ... Any of the following acts by an insurer, if committed without just cause and performed with such frequency as to indicate a general business practice, shall constitute unfair claims settlement practices...
>
> (4) not attempting in good faith to effectuate prompt, fair and equitable settlements of claims submitted in which liability has become reasonably clear...

Emergency room claims were reviewed to determine whether the Company was in compliance with the prudent lay person standard of care. During that review, several claims were noted as being denied as not medically necessary when the diagnosis involved fit within the parameter of the prudent lay person standard.

It is recommended that United HealthCare discontinue its use of a prepared list of emergency room diagnoses it declares ineligible for coverage. Instead, it is recommended that the Company consider each claim separately on its merits.

It is recommended that the Company adhere to provisions within the contract setting forth a prudent lay person standard as defined in §3216(i), §3221(k)(4) and §4303(a)(2) of the New York State Insurance Law.

It is further recommended that the Company comply with the provisions of New York Insurance Law §2601(a)(4) in its the settlement of all emergency room claims.

D. Foreign Claims

United HealthCare's procedure for the payment of claims for services rendered outside the US allows claims payable directly to the insured and valued at a certain level to be paid without additional auditing. Claims payable to a provider where payment value falls into a second threshold require confirmation of service by the subscriber, while claims meeting a third dollar threshold are referred to the Company's fraud oversight group.

Typically, service outside of the US is difficult to confirm, so insurance fraud is easier to commit. Providers are often unknown and thus even their credentials are unconfirmable. Further, the possibility for collusion is high. For these reasons, direct payment and simple confirmation are insufficient to provide assurance that claims are legitimate.

Thus, it is recommended that the Company reevaluate the level at which foreign claims will be referred to its fraud oversight group for investigation prior to payment.

E. Explanation of Benefit Statements

As part of the review of United HealthCare's claims practices and procedures, an analysis of the Explanation of Benefits statements ("EOB") sent to subscribers and/or providers was performed. An EOB is an important link between the subscriber, provider and United HealthCare. It should clearly communicate to the subscriber and/or provider that United HealthCare has processed a claim and how that claim was processed. It should correctly describe the charges submitted, the date the claim was received, the amount allowed for the services rendered and show any balance owed the provider. It should also serve as the necessary documentation to recover any money from coordination of benefits with other insurance carriers. Analysis of the Explanation of Benefit statements yielded the following findings:

For certain products, when a United HealthCare subscriber goes to a specialist for medical attention, it is necessary for that subscriber to have obtained authorization from their primary care physician beforehand. If authorization is not obtained, submitted claims for service will be denied and an Explanation of Benefits statement ("EOB") sent out to the subscriber and to the provider advising them of the following:

> "According to our records, a network health care provider was used. According to your plan, a pre-authorization was required but not obtained. Therefore, we have declined payment for the service because the health care provider did not obtain the authorization. According to the network contract, the member may not be billed for the declined amount. However, the member is responsible for the network plan co-pay, deductible or coinsurance amounts."

Often, however, the specialist or the subscriber will have submitted their claim to the Company before the Company has had an opportunity to enter the necessary authorization into the system or before the Company has been notified of the authorization by the primary care physician. When this occurs, the initial EOB may confuse the subscriber because the denial does not leave room for the possibility that the authorization may simply not have been entered into the system or may be late.

This same situation holds true with the EOB used for emergency room treatment. In that case as well, emergency room treatment is denied when it is simply the intent of the insurer to obtain additional information about the emergency room visit.

It is recommended that the Explanation of Benefits text on denied claims be amended to indicate to subscribers and providers that if additional information is provided, the denied claim will be reconsidered upon receipt of the information. Additionally, when the Company is aware that additional specific information is needed to allow the processing of a claim, said Explanation of Benefits form or system generated letter should indicate such clearly.

The EOB forms do not provide a sufficient description of the submitted charges. In many cases, non-specific terms such as "Medical Care", and "Other", are routinely used to describe the submitted charges. During United HealthCare's processing of claims, services and procedures are designated by a five digit code (CPT code) taken from the "Physician's Current Procedural Terminology" manual, published by the

American Medical Association. If United HealthCare would display these CPT codes on its EOBs along with a brief description, a satisfactory explanation of the submitted charges could be provided to the subscriber. This addition could also have the added effect of decreasing the possibility of provider fraud by ensuring that the subscriber has an opportunity to see what procedures are being billed.

It is recommended that the Company display the five-digit CPT codes for procedures and services that it used to determine payment on all Explanation of Benefit statements along with a brief description of the codes.

The provider's address is not reflected on the EOBs. This information is helpful to the subscriber to assist in identifying the location of the provider performing the service.

It is recommended that EOBs sent to subscribers include the address of the provider performing the services.

United HealthCare does not include the date a claim was received on the EOB. This claim receipt date is of particular importance to subscribers and/or providers given the enactment of §3224-a of the New York Insurance Law ("Standards for prompt, fair and equitable settlement of claims for health care and payments for health care services"). Without disclosure of the receipt date, a subscriber and/or the provider cannot determine if any interest is due relative to a claim that took longer than 45 days to process.

It is recommended that the Company modify their Explanation of Benefits statement form to include the date the claim was received in order to comply with the intent of the prompt pay laws.

Section 3234(b) of the New York Insurance Law states in part:

"(b) The explanation of benefit statement form must include at least the following:..."

"(7)...a description of the time limit, place and manner in which an appeal of a denial of benefits must be brought under the policy or certificate and notification that failure to comply with such requirements may lead to forfeiture of a consumer's right to challenge a denial or rejection, even when a request for clarification has been made."

The text on the Company's EOB states the following:

"A review of this benefit statement may be requested by following the steps outlined in your benefit booklet under "How to Appeal a Claim" or "Your Rights Under ERISA". The request must be made within 60 days of receiving this statement."

The statement used by the Company does not include all of the requisite information on their Explanation of Benefits Statements. Accordingly, subscribers and/or providers are not being properly informed of their appeal rights.

It is recommended that United HealthCare modify their Explanations of Benefits statement form to comply with §3234(b) of the New York Insurance Law regarding rights of appeal.

F. New York Bad Debt and Charity Pool Surcharge

The Company did not withhold the New York Bad Debt and Charity Pool Surcharge on certain capitated agreements as required by New York Public Health Law §2807-s and §2807-t.

It is recommended that the Company retroactively calculate and pay the New York Health Law §2807-t Debt and Charity Pool on capitated groups it failed to properly account for.

It should be noted that subsequent to this finding, the Company was able to demonstrate it had complied with this recommendation.

The Company has also acknowledged several surcharge errors that resulted from a claim processor's failure to manually calculate the surcharge as required. Additionally, the Company acknowledged certain surchargeable providers were inadvertently neglected from the surcharge calculation.

It is recommended that the Company retroactively determine any surcharge amounts due but not paid as a result of eligible providers not being listed in the system as so eligible.

5. PROMPT PAY

A. Claim Sampling

Claims were tested to determine the Company's compliance with §3224-a of the New York Insurance Law, "Standards for prompt, fair and equitable settlements of claims for health care and payments for health care service". Said section contains provisions outlining the time frames within which claims must be paid or have interest paid on the unpaid portions thereof. Initial review indicated that the Company paid no interest on any claims, except Medicare/Medicaid claims, between January 23, 1998, the inception date of the Prompt Pay Law, and December 31, 1998.

The claims tested were selected from the population of claims submitted during May 1998 and December 1998. This population consisted of 283,069 claims valued at $38,799,457. In order to obtain a random sample, statistical sampling was performed on the population.

First, claims that took greater than 45 days to adjudicate were tested to determine the Company's compliance with subsection (b) of §3224-a. The subsection reads in pertinent part as follows:

> "In a case where the obligation of an insurer ... is not reasonably clear... the corporation shall...notify the policyholders, covered person or health care provider in writing within 30 days of the receipt of the claim: (1) that it is not obligated to pay the claim or make the medical payment, stating the specific reasons why it is not liable; or (2) to request all additional

> information needed to determine liability to pay the claim or make the health care payment."

There were 8,275 claims not paid within 45 days. A sample of 87 claims from this population was tested to determine whether letters were sent. Of the 87 claims tested, forty-six percent, or forty, of the sample were found to be in violation. This statistic can be extrapolated to a conclusion that there may be as many as 3,346 violations of this law in the referenced two month period.

Second, claims that were unpaid after 45 days that appeared to be otherwise eligible for interest were sampled to determine whether interest was paid as required by subsection (c) of §3224-a of the New York Insurance Law. The subsection reads in pertinent part as follows:

> "...any insurer ... that fails to adhere to the standards contained in this section shall be obligated to pay to the health care provider or person submitting the claim,... the amount of the claim or health care payment plus interest on the amount of such claim or health care payment..."

Where interest was not paid, this sample was then tested to determine the cause for such failure.

There were 1,911 claims valued at $2,629,192 that may have been eligible for interest. One hundred thirty-three claims from this population were tested. Forty-two percent, or 56 of this sample were found to have been eligible for interest but did not have such interest paid. This statistic can be extrapolated to a possible total of 802 violations of this law in the referenced two-month period.

The Company's failure to pay these claims within a 45 day period also appears to be a violation of subsection (a) of New York Insurance Law §3224-a, which requires that "clean claims" be paid within forty-five days of receipt.

Subsequent to this finding, the Company calculated and paid interest on those claims that were found to be interest-eligible in the examiner's sample.

Reasons for the failure to pay interest included the following:

- Claims that either had their denials reversed or were adjusted upwards as a result of company error did not have interest paid.
- Claims that were held up in Medical Review were not deemed eligible for interest even when no additional information was sought from either the subscriber or the provider. Such claims are held to be interest eligible because, with no clarification sought, the obligation of the insurer should have been reasonably clear.
- Claims were legitimately delayed as a result of requests for Coordination of Benefits ("COB") data. When the data arrived, however, all such claims within the subscriber's history were not re-opened and paid. Then, when the claims were re-opened, the interest was not applied.
- Payment schedules for providers were not loaded into the system in a timely manner. As a result, many payments were below the contracted rate. Once loaded, the providers would receive retroactive compensation, but not interest for the unpaid portion.

- Claims that were held up pending the negotiation of new provider contracts were not considered interest-eligible.
- The Company withheld claim payments for the employees of policyholders who did not pay their premiums within the policy grace period. When the premiums were ultimately paid, the withheld claims were not deemed to be interest-eligible. The decision to maintain delinquent policyholders is entirely that of the Company. Unless the Company actually cancels the employees of such delinquent groups, there is an obligation to pay legitimate claims when submitted by providers.

Overall, it may be concluded that the Company was remiss in its application of the Prompt Pay Law. While the Company did establish procedures to comply with the law, no steps had been taken to ensure those procedures were followed. The strength of this conclusion is especially noted in the Company's failure to make any interest payments other than for its Medicare/Medicaid business from January 23, 1998, the date of the inception of the Prompt Pay Law through December 31, 1998.

It is recommended that the Company take steps to ensure that the provisions of §3224-a of the New York Insurance Law regarding the prompt payment of claims are fully implemented and complied with.

Subsequent to the finding, the Company presented the examiners with a detailed action plan that was developed to bring the Company into compliance with the provisions

of the Prompt Pay Law. This action plan, implementation of which was not verified, appears to address the case specific causes behind the Company's failure to pay interest.

It is further recommended that the Company review all claims that may have been eligible for interest since January 23, 1998 to determine whether interest is due on such claims. Where the claims are found to be eligible for interest, such interest should be paid in compliance with New York Insurance Law §3224-a(c).

B. Interest Calculations

Processing procedures require that interest be calculated by hand. When a claim has interest due, a mathematical formula must be computed on a battery-operated calculator. Once calculated, interest due must be manually inputted into the system for payment and accounting purposes. Such processes are flawed in that the possibility of human error exists.

It is recommended that the Company install an automated procedure to calculate and pay interest.

Subsequent to the finding, the Company presented a request to its Information Systems Department to automate the processes used to calculate the payment of prompt pay interest. Such change was not implemented during the course of the examination.

It is further recommended that the Company's Quality Assurance Department establish a procedure to test New York claims for the appropriate application of interest.

C. Supervisory Notification

When a claim is determined to be eligible for interest, internal procedures require that claim processors notify their supervisors. The Company maintains this requirement was implemented with the intent of expediting the claims paying process by having late claim referred to more senior staff. In light of the fact that no interest was paid on non-Medicare/Medicaid claims during the calendar year 1998, the Company should consider whether the requirement that supervisors be notified may discourage processors from paying interest in order to avoid having to communicate the fact to their supervisor.

It is recommended that those who calculate interest be given autonomy to pay interest without having to notify their supervisors.

D. Bulk Payments

The Company has a policy whereby claim payments are withheld for shipment until a sufficient number of claims has been accumulated. The Company maintains this is done for the convenience of its providers. The Company's position is that bulk payments are easier for the providers to handle and the amount of their paperwork is reduced. Although there were no written agreements, the Company indicates the providers have accepted this arrangement and have made no requests for removal from

the bulk payment process. The Company's position is that interest should not accrue as a result of the bulk mail delay.

Without a written agreement by the providers, the Prompt Pay Law tenets cannot be avoided. Bulk payments delay claims and may place them outside the acceptable 45-day limit. Bulk payment delays may also increase amounts of interest due and cause claims, not otherwise eligible for interest, to become qualified for said interest.

As a further issue, as noted elsewhere in this report, the calculation of interest, when due, is performed by claim adjudicators. These individuals calculate the interest when the claim is processed. They are not aware of when the claim payments will be mailed, and thus, their interest calculations cannot be correct.

It is recommended that interest be accrued during the period in which claims are withheld for the purpose of making bulk payments.

It is recommended that interest paid be calculated to include the date that the check is to be printed and mailed.

Subsequent to this finding, the Company developed a policy to comply with these recommendations.

E. Retroactive payment of claims

Certain prompt pay violations were found that were the result of the Company improperly denying claims because of the suspension of the group to which the subscriber belonged for non-payment of premiums. In other words, a middle market group (population from 50 to 250) that did not pay their premium when due was not terminated. Rather, the Company denied claims from the group using other reasons, then retroactively paid the claims when the policyholder paid the overdue premiums. This procedure unfairly transfers risk for unpaid premiums to the providers. Any "clean" claims so delayed are potential violations of Section 3224-a(a) and (c). If the policyholder never paid the premiums, the claims would never have been paid. Neither would the providers have been advised that the patient was no longer covered by the insurer.

It is recommended that the Company calculate and pay interest on claims pended while awaiting overdue premiums, where such claims are eligible for interest pursuant to Section 3224-a(c).

6. UTILIZATION REVIEW

A. Department of Insurance Complaints

New York Regulation 64 Part 216.4(d) and the Company's own written Policies and Procedures state that all complaints received from the Insurance Department are to go directly to the Consumer Affairs Department where they are to be logged in. Further, NY Circular Letter No. 11 (1978) mandates the items that are to be maintained in such a

log. Ten such complaints were sampled, and thirty percent of the sample tested were not properly logged.

It is recommended that the Company implement standards to ensure it adheres to Regulation 64 Part 216.4(d), Circular Letter No. 11 (1978) and its own Policy and Procedures by having the Consumer Affairs Department log all consumer complaints received through the Department of Insurance.

Regulation 64 Part 216.4(d) states in part that every insurer, upon receipt of any inquiry from the Insurance Department respecting a claim, shall within 10 business days, furnish the Department with information requested respecting the claim. The examiner tested a sample of thirty-four Insurance Department requests for information to determine the Company's compliance with this regulation. Twenty-one percent, or five, of the informational requests could either not be found or were not responded to in a timely manner.

It is recommended that the Insurance Company implement standards to ensure it adheres to Regulation 64 Part 216.4(d) by responding to the Department's complaint inquiries within the mandated ten-day time frame.

B. Grievances

United HealthCare Insurance Company of New York, Inc. has no managed care health insurance contracts as defined in §4801(c) of the New York Insurance Law.

Circular Letter No.5 (1999) states in part that insurers do not need to report grievance information to the Department in their annual statements if they do not have a product meeting §4801(c) of the New York Insurance Law definition. However, if those insurers have voluntarily implemented a grievance procedure not subject to the provisions of Chapter 705 of the laws of 1996, they are encouraged to report such grievance information in their annual statement. They should, however, note that such information comes from a voluntary program.

Although the Insurance Company does maintain such a grievance procedure, it did not report any grievances in the annual statement.

It is recommended that the Insurance Company agree to voluntarily report all grievance cases in its annual statement.

A review of the Plan's subscriber contract was conducted to verify if the grievance procedure was included in the contract and whether it complied with §4408-a of the New York Public Health Law. Said Section 4408-a (4) requires that grievances be resolved in an expeditious manner, and in any event, no more than:

(i) thirty days after the receipt of all necessary information in the case of requests for referral and

(ii) forty-five days after the receipt of all necessary information in all other instances.

The Plans' contract wording is not consistent with §4408-a (4), of the New York Public Health Law because said contract states that the Company will perform investigations and resolve complaints based on the following time frames:

(i) 30 business days after the receipt of all necessary information in the case of requests for referral; and

(ii) 45 business days after receipt of all necessary information in all other complaints in writing.

The use of business days, instead of calendar days gives the Company more time to resolve the grievances than the law intends.

It is recommended that the Plans comply with §4408-a (4) of the New York Public Health Law by amending their HMO contracts to state that grievances will be resolved within the appropriate number of "calendar" days as opposed to "business" days.

Grievance files from the two New York Public Health Law Article 44 HMOs were reviewed for compliance with the time parameters required by §4408-a of the New York Public Health Law. Results of that review indicate that thirty-seven percent, or thirty-five of the ninety-four files tested, were either missing acknowledgment letters or had those acknowledgement letters sent late. Additionally, eighteen percent, or seventeen

of the grievances were resolved outside of the required parameters. It should be noted that an additional five files could not be located by the Company.

It is recommended that the Plans adhere to §4408-a(4) of the New York Public Health Law by ensuring that subscribers submitting grievances have acknowledgment letters issued within the required fifteen-day time limit. Further, it is recommended that the grievances be resolved within the law's prescribed time frames.

Section 4408-a(6) of the New York Public Health Law requires that notice of determination of the grievance shall be made in writing to the insured or to the insured's designee. Additionally, the Company's own policy requires this. In twenty-one percent, or twenty of the ninety-four cases reviewed, there was no documentation in the file to indicate that any determination notice was sent to the insured or to the insured's designee.

It is recommended that the Plans comply with §4408-a(6) of the New York Public Health Law and its own policies by ensuring that determination notices are sent to the insured or to the insured's designee following the resolution of a grievance.

Section 4408-a (10) of the New York Public Health Law and the Plan's own policy requires that the determination of an appeal of a grievance on a clinical matter must be made by personnel qualified to review the appeal, including licensed, certified or registered health care professionals who did not make the initial determination. In three

percent, or two of the ninety-four cases reviewed, the person who made the initial determination also reviewed the appeal of a grievance.

It is recommended that the Plans adhere to §4408-a(10) of the Public Health Law and their own policy by ensuring that only qualified personnel be permitted to review appeals of grievances.

C. Utilization Review Appeals

The only appeals that are subject to the utilization review appeals process are those denials for service based on the grounds that the service was not medically necessary.

The utilization review log supplied by the Downstate HMO included both grievances and utilization reviews. Letters were used to differentiate between the two; "G" for grievances, and "A" for utilization reviews. When the actual files were reviewed, however, it was noted that in some cases, the symbol "A" represented a grievance appeal and not a utilization review appeal.

It is recommended that the United HealthCare of New York, Inc. maintain separate logs for their grievance files and their utilization review files.

Section 4904(d) of the New York Insurance Law and §4904(b)(4) of the New York Public Health Law state that both expedited and standard utilization review appeals

shall be handled by a clinical peer reviewer other than the clinical peer reviewer who rendered the initial determination. Additionally, the Company's own policy requires this. However, in eight percent, or four of the fifty-two cases tested, the same person who reviewed the appeal also rendered the initial adverse determination.

It is recommended that the Upstate Plan adhere to §4904(d) of the New York Insurance Law, §4904(b)(4) of the New York Public Health Law and their own policies by ensuring that in every case, utilization review appeals be handled by clinical peer reviewers other than the reviewer that issued the initial determination.

7. INTERNAL AUDIT

During the examination period, the Internal Audit department at United HealthCare was a division of the national office. There were no staff assigned specifically to the New York Companies.

The Company reported that no internal defalcations of any amounts greater than $500 occurred during the examination period. This seems unlikely in light of the fact that there were no audits directed specifically at the New York Companies.

It is recommended that the Company address the issue of security and internal controls at the New York Companies.

8. RECORDS RETENTION

One of the computer systems used by the Insurance Company (the IMCS system), overlaid the field "date received" within the claim processing system when a "dirty" claim was reprocessed. As a result, there was no way to determine the original received date for many of the claims within the system. This is a violation of Regulation 152, Section 243.2, which requires that the claim file shall show clearly the dates that forms and other documents were received. It is also a violation of Regulation 64 Part 216.11 which requires that all insurers maintain all data within the claim files so that the Insurance Department examiners can reconstruct the claim. While this Regulation does not directly apply to the HMOs, good business practice dictates that the Regulation be applied similarly.

The Company maintains that as of January 1, 2000, the IMCS system is no longer used to initiate claim processing.

During examination of the timeliness of the Company's response to subscriber complaints received through the Department, as described in Section 3 herein, the Company was not able to locate two of the sample files requested. This is a violation of Regulation 152 Part 243.2(b)(6), as regards the Insurance Company, which requires that all complaint records be maintained for six years after the complaint has been closed.

It is recommended that the Company comply with all aspects of Regulation 152 regarding records retention.

9. FRAUD PREVENTION

Between the period January 1998 and September 1999, the Company received 470 fraud referrals. Of these 470, a total of 136 cases were opened; 30 in 1998, and 106 in 1999.

As of September 1999, 57% of the fraud cases opened during 1998 were unresolved. The longer the Company waits to resolve these issues, the less chance there is of recovering claim dollars paid out improperly due to fraud.

It is recommended that the Company attach a higher priority to the investigation and resolution of fraud allegations.

10. SUMMARY OF COMMENTS AND RECOMMENDATIONS

ITEM		PAGE NO.
	MANAGEMENT	
A.	It is recommended that the Company implement the notification and certification requirements of Circular Letter No. 9 (1999).	5
B.	It is recommended that the Company comply with Circular Letter No. 9 (1999) and update all processing guidelines, regardless of format, to ensure they are consistent and in compliance with New York's mandates on health care.	5
	SALES/UNDERWRITING	
C.	It is recommended that the Company provide its toll-free telephone number to potential subscribers in its advertising medium. Further, the toll-free telephone number should include enrollment information as a voice mail option.	7
D.	It is recommended that the Company comply with §4317 of the New York Insurance Law and offer small group policies to groups of between two and fifty regardless of marital status.	7
E.	It is recommended that the revised New Member Letter use the application date and not the effective date, for the purpose of calculating continuing coverage as required by New York Insurance Law §4318(a) and (b).	9
F.	It is recommended that the Company determine how the	9

document that was violative of New York Insurance Law §4318 was originally approved for distribution in order to prevent a reoccurrence.

G. It is recommended that the Company take steps to ensure that rates charged are approved and properly billed as required by New York Insurance Law §4308(b). 10

H. It is recommended that the Company comply with New York Insurance Law §4308(b) and utilize an experience-rating formula that has been approved by the Department. 11

I. It is recommended that the Companies maintain current licenses on file for all of their active producers to ensure continued compliance with §2116 of the New York Insurance Law. 12

J. It is recommended that the Company initiate a written agreement with its individual producers. Additionally, it is recommended that the Upstate Plan formalize an agreement with its general agents. 13

K. It is recommended that United HealthCare license its internal agents to confirm compliance with NY Insurance Law §2114(a)(3). 14

L. It is recommended that United HealthCare of Upstate New York, Inc. file certificates of appointment for each of its agents as required by New York Insurance Law §2112(a). 14

M. It is recommended that the United HealthCare Companies improve their record keeping as regards agents and brokers. 15

CLAIM PROCESSING

N. United HealthCare indicates that an independent auditor will be auditing certain of the EDI companies for compliance with the claim submission standards and it is recommended they do so. 16

O. It is recommended that the Company develop a system that will permit it to determine the exact count and inventory of NY claims at any given point in time as required by the Department and in the case of the two HMOs as required by 10 NYCRR Part 98.11(a). 18

P. It is recommended that the Company utilize its approved plan on a consistent basis or otherwise accurately report claim counts and values in its Schedule H filings in compliance with New York Insurance Law §308. 18

Q. It is recommended that United HealthCare discontinue its use of a prepared list of emergency room diagnoses it declares ineligible for coverage. Instead, it is recommended that the Company consider each claim separately on its merits. 19

R. It is recommended that the Company adhere to provisions within the contract setting forth a prudent lay person standard as defined in §3216(i), §3221(k)(4) and §4303(a)(2) of the New York State Insurance Law. 20

S. It is recommended that the Company comply with the provisions of New York Insurance Law §2601(a)(4) in its the settlement of 20

all emergency room claims.

T. It is recommended that the Company reevaluate the level at which foreign claims will be referred to its fraud oversight group for investigation prior to payment. 20

U. It is recommended that the Explanation of Benefits text on denied claims be amended to indicate to subscribers and providers that if additional information is provided, the denied claim will be reconsidered upon receipt of the information. Additionally, when the Company is aware that additional specific information is needed to allow the processing of a claim, said Explanation of Benefits form or system generated letter should indicate such clearly. 22

V. It is recommended that the Company display the five-digit CPT codes for procedures and services that it used to determine payment on all Explanation of Benefit statements along with a brief description of the codes. 23

W. It is recommended that EOBs sent to subscribers include the address of the provider performing the services. 23

X. It is recommended that the Company modify their Explanation of Benefits statement form to include the date the claim was received in order to comply with the intent of the prompt pay laws. 24

Y. It is recommended that United HealthCare modify their 24

Explanations of Benefits statement form to comply with §3234(b) of the New York Insurance Law regarding rights of appeal.

Z. It is recommended that the Company retroactively calculate and pay the New York Health Law §2807-t Debt and Charity Pool on capitated groups it failed to properly account for. 25

AA. It is recommended that the Company retroactively determine any surcharge amounts due but not paid as a result of eligible providers not being listed in the system as so eligible. 25

PROMPT PAY

AB. It is recommended that the Company take steps to ensure that the provisions of §3224-a of the New York Insurance Law regarding the prompt payment of claims are fully implemented and complied with. 29

AC. It is further recommended that the Company review all claims that may have been eligible for interest since January 23, 1998 to determine whether interest is due on such claims. Where the claims are found to be eligible for interest, such interest should be paid in compliance with New York Insurance Law §3224-a(c). 30

AD. It is recommended that the Company install an automated procedure to calculate and pay interest. 30

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utilization review appeals be handled by clinical peer reviewers other than the reviewer that issued the initial determination.

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AS. It is recommended that the Company address the issue of security and internal controls at the New York Companies. 39

RECORDS RETENTION

AT. It is recommended that the Company comply with all aspects of Regulation 152 regarding records retention. 40

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AU. It is recommended that the Company attach a higher priority to the investigation and resolution of fraud allegations. 41

Respectfully submitted,

Bruce Borofsky

Bruce Borofsky

Senior Insurance Examiner

STATE OF NEW YORK)

) SS.

)

COUNTY OF NEW YORK)

Bruce Borofsky, being duly sworn, deposes and says that the foregoing report submitted by him is true to the best of his knowledge and belief.

Bruce Borofsky

Bruce Borofsky

Subscribed and sworn to before me

This 30th day of January 2001

Charles T. Lovejoy

Charles T. Lovejoy
Notary Public, State of New York
No. 31-4758852
Qualified in New York County
Commission Expires 1-28-02

Appointment No. 021360

STATE OF NEW YORK
INSURANCE DEPARTMENT

I, NEIL D. LEVIN *, Superintendent of Insurance of the State of New York, pursuant to the provisions of the Insurance Law, do hereby appoint:*

Bruce Borofsky

as a proper person to examine into the affairs of the

United HealthCare Insurance Company of New York

and to make a report to me in writing of the condition of the said

Company

with such other information as he shall deem requisite.

In Witness Whereof, I have hereunto subscribed by the name and affixed the official Seal of this Department, at the City of New York.

this 16th *day of* February *1999*

NEIL D. LEVIN
Superintendent of Insurance

(by) Deputy Superintendent

SPECIAL MARKET CONDUCT

REPORT ON EXAMINATION

OF

UNITED HEALTHCARE OF NEW YORK, INC.

AND

UNITED HEALTHCARE INSURANCE COMPANY OF NEW YORK

AS OF

MARCH 31, 2003

DATE OF REPORT: MAY 1, 2003

EXAMINER: KATHLEEN GROGAN

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STATE OF NEW YORK
INSURANCE DEPARTMENT
25 BEAVER STREET
NEW YORK, NEW YORK 10004

George E. Pataki
Governor

Gregory V. Serio
Superintendent

May 1, 2003

Honorable Gregory V. Serio
Superintendent of Insurance
Albany, New York 12257

Sir:

Pursuant to the provisions of the New York Insurance Law and acting in accordance with directions contained in Appointment Numbers 21951 and 21952 dated November 15, 2002, attached hereto, I have made a special market conduct examination into the condition and affairs of UnitedHealthcare of New York, Inc. a health maintenance organization certified under Article 44 of the New York Public Health Law; and United HealthCare Insurance Company of New York, an accident and health insurer licensed pursuant to the provisions of Article 42 of the Insurance Law as of March 31, 2003. The examination was conducted at the Companies' home office located at 2 Pennsylvania Plaza, New York, New York. The following report thereon is respectfully submitted.

Whenever the terms "UHC of NY" or "the HMO" appears in this report without qualification it should be understood to refer to UnitedHealthcare of New York, Inc. Whenever the term "UHC Insurance Co. of NY" appears in this report without qualification it should be understood to refer to United HealthCare Insurance Company of New York. Whenever the terms "the Companies" or "UHC" appear in this report they should be understood collectively to refer to United HealthCare Insurance Company of New York and to UnitedHealthcare of New York, Inc.

1. SCOPE OF EXAMINATION

The special examination was conducted to review compliance with Sections 4308(b) and 4308(g) ("file and use") of the New York Insurance Law. It was targeted toward a review of the manner in which UHC developed and implemented its file and use applications for premium rate increases that were submitted to be effective in the third quarter of 2002 and the first quarter of 2003. The examination scope was expanded to cover the 15-month period January 1, 2002 through March 31, 2003 however; transactions prior to and subsequent to this period were reviewed where deemed appropriate.

The review also concentrated on validating business segment (i.e. individual, small group, large group and Healthy New York) data as presented in UHC of NY's filed 2001 Annual Statement and quarterly statements for the period January 1, 2002 through the first quarter of 2003. In addition, UHC's 2001 "Loss Ratio Report" filing made pursuant to Section 4308(h) of the New York Insurance Law was reviewed.

The examination included a review of the activities of United Healthcare of Upstate New York. Effective December 31, 2002, the business was merged into UHC of NY.

This report on special examination is confined to comments on those issues that involve matters that deviate from laws, regulations and rules, or which are deemed to require an explanation or description.

2. DESCRIPTION OF COMPANIES

UHC of NY is a health maintenance organization (HMO) certified under Article 44 of the New York Public Health Law. UHC Insurance Co. of NY is a for-profit accident and health insurer licensed under Article 42 of the New York Insurance Law. United Healthcare of Upstate New York (UHC of Upstate NY) was an HMO, certified under Article 44 of the Public Health Law. Effective December 31, 2002, UHC of Upstate NY was merged into UHC of NY.

UHC of NY's immediate parent is UnitedHealthcare, Inc., which is a subsidiary of United HealthCare Services, Inc., a Minnesota company. UHC Insurance Company's immediate parent is United HealthCare Insurance Company, a Connecticut company. Both UHC of NY and UHC Insurance Co. of NY are ultimately subsidiaries of the UnitedHealth Group, Inc. (UnitedHealth Group), a publicly traded company.

UHC of NY markets a Health Maintenance Organization ("HMO") product, offering in-network benefits only and a Point of Service ("POS") product offering in-network and out-of-network benefits. The POS contract is split between UHC of NY writing the HMO (in-network) portion of the business and UHC Insurance Co of NY writing the out-of-network (POS) portion of the business. The HMO product is entirely written by UHC of NY. Additionally, a Preferred Provider Organization ("PPO") product is offered via UHC Insurance Co. of NY.

Prior to the merger with UHC of Upstate New York, UHC of NY operated in the following counties: Bronx, Nassau, Putnam, Rockland, Dutchess, New York, Queens, Suffolk, Kings, Orange, Richmond, Ulster and Westchester. After the merger, the following counties were added: Cayuga, Herkimer, Madison, Oneida, Onondaga, and Oswego.

UHC of NY maintains a management services agreement, effective November 1, 1977, with its intermediate parent company, United HealthCare Services Inc. (UHS). Under the service agreement, UHS performs a wide variety of management and administrative services for a fee. The service agreement states that UHC of NY will pay a monthly management fee based on actual costs. The total fees paid under the agreement for the years 2001 and 2002 were $24,785,000 and $32,267,000, respectively. The 2002 figure represents the fee paid on behalf of UHC of NY and incorporates the fee paid by UHC of Upstate NY. United Healthcare Service, LLC, and independent adjuster licensed in New York, also performs similar services for UHC Insurance Co. of NY.

3. EXECUTIVE SUMMARY

The findings and recommendations noted herein reflect weakness in internal controls and procedures as they pertain to the integration of the financial reporting and rate making functions. Also highlighted are weaknesses in UHC's ability to segregate data by business segment and UHC's implementation of rate adjustments. Examples of this are reflected in:

- Submission of inaccurate Annual and Quarterly Financial Statements and New York Data Requirements in violation of Sections 307 and 308 of the New York Insurance Law.

- UHC of NY's inability to provide adequate support to justify its business segment expense allocation formulas as utilized during the period under examination.

- Submission of inaccurate Loss Ratio reports in violation of Section 4308(h) of the Insurance Law.

- Incorrect premium rates charged to UHC's individual, small group and Healthy New York policyholders throughout the period January 1, 2002 through March 31, 2003, in violation of Section 4308(g) of the Insurance Law.

- Certain UHC of NY large group HMO policyholders were charged a rate different from those on file, in violation of Section 4308(b) of the Insurance Law.

- Lack of sufficient oversight of UHC's third party administrator ("TPA") which was contracted to administer the billing functions of its direct pay policies.

4. FINANCIAL STATEMENT REPORTING

Both UHC of NY and UHC Insurance Company of NY file their financial statements on the required NAIC Health Blank. Additionally both companies are required to file additional supplementary data. UHC of NY is required to submit a New York Data Requirements supplement along with the NAIC filing and UHC Insurance Co. of NY is required to submit a "Supplement to Life and Accident and Health Annual Statement."

- New York Data Requirements

A review of UHC of NY's filed Data Requirements, annual and quarterly statements for the calendar year 2001 and the first three quarters of 2002 revealed that UHC of NY incorrectly reported premiums, claims and incorrectly allocated general administrative expenses to business segments. Accordingly, there was a distortion of underwriting results reported on its large group, small group and direct pay business segments. This is particularly troublesome considering that the HMO amended its 2001 Annual Statement five times subsequent to its initial submission. Amendments to certain 2002 Quarterly Statements were also submitted to the Department during 2002 and early 2003.

The amended filings were made primarily in response to correspondence resulting from the Department's review of the statements. The original filing reported identical Per Member per Month ("PMPM") premium income and claims figures across certain lines of business (e.g. HMO, POS). Further, for each of these lines of business, UHC of NY reported identical PMPM figures for HMO Large, Small and Individual business segments. Follow-up correspondence from the Department focused on continued errors in the data presented in the Statement of Revenue and Expenses by business segment. After four revisions submitted to the Department, the inaccuracies within the financial statements were still not corrected. When this matter was discussed at a meeting, held at the Department on January 23, 2003, UHC of NY agreed to again re-file their statements a fifth time in an attempt to finally correct the errors.

Based upon review of the documents submitted to the Department, it was determined that the 2001 Annual New York Data Requirements and the 2002 Quarterly New York Data Requirements contained erroneous data. This resulted in misstatements to the business segment results for all lines of business in violation of Sections 307 and 308 of the New York Insurance Law. These misstatements to the reported gain or loss for each line of business should have been "caught" by the persons preparing these statements beforehand, but they did not affect the total amount of premium income or claims incurred.

The Annual and Quarterly New York Data Requirements is filed with the Department pursuant to Sections 307 and 308 of the New York Insurance Law with a Jurat where the accuracy of the statement and related exhibits, schedules and explanations are attested to by the HMO's principal officers, according to their best knowledge and belief.

Allocation of administrative expenses to lines of business and business segments was also reviewed and found to be identical in a number of cases. UHC of NY's intermediate parent, UHS performs most management and administrative services for UHC of NY under a service agreement approved by the Department that requires that such expenses be allocated on an actual cost basis.

UHC of NY stated that the percentage of expenses allocated to each product line was developed using the total member months on each the following product lines: HMO, HMO in network, Medicaid, Medicare and Child Health Plus. A factor is then applied to the member months figures for each product line. UHC of NY was unable to provide adequate supporting documentation relative to the cost allocation factors used to prepare their financial statements.

It is recommended that UHC of NY present accurate information in its financial statements pursuant to Sections 307 and 308 of the New York Insurance Law.

It is recommended that UHC of NY improve its process of oversight and review of the preparation of its statutory financial statements.

It is recommended that UHC of NY management take immediate steps to develop, and put into use, a methodology for reporting premiums and claims by business segment that is based upon actual data for each such business segment.

It is recommended that when UHC of NY allocates administrative expenses it must either use actual cost allocations for each line of business or business segments reported in its financial statements, or be able to provide adequate support for the appropriate allocation factors which will be the basis for the application of the administrative expenses. Additionally, it is recommended that the basis for allocation be reviewed periodically, at least annually.

UHC of NY submitted a corrected 2001 annual report, as attested to by its officers on the Jurat Page of its filed financial statement, to the Department in March of 2003. Similarly, corrected 2002 reports were submitted to the Department in April of 2003.

- Loss Ratio Report

Healthcare companies are required to file a "Loss Ratio Report" with the Department, annually, on May first, pursuant to Section 4308(h), which states:

> "Corporations subject to the provisions of this article shall annually report, no later than May first of each year, the loss ratio calculated pursuant to this subsection for each such contract form for the previous calendar year."

The 2001 loss ratio report was filed with the Department on May 1, 2002 with the required actuarial certification duly signed by its in-house actuary. The 2001 loss ratio report was revised on April 3, 2003. The following chart is a comparison of the loss ratios for the direct pay contracts as presented in the loss ratio report, filed with the Department on May 1, 2002 and the April 3, 2002 revised loss ratio report:

Line of Business	Loss Ratio Report	Revised Loss Ratio Report
HMO	148.25%	103%
POS (In Network)	249.08%	143%
Combined	181.98%	118%

It is recommended that UHC take the necessary steps to ensure that the submission of its Loss Ratio Reports filed pursuant to Section 4308(h) of the Insurance Law are accurate.

- Rate Application

UHC submitted a rate application filing dated November 5, 2002, pursuant to Section 4308(g) of the New York Insurance Law, which contained a certification by its actuary that the filing is in compliance with the prescribed loss ratios. The rate application submission was to be effective January 1, 2003 and indicated a rate increase of 45.1% for the HMO line of business and 68% on the POS line of business relative to direct pay subscribers. The rate application also denoted increases for all small and large group HMO and POS products in differing amounts ranging from 16% - 43% as well as rate increases on prescription drug riders.

UHC of NY amended its 2001 annual New York Data Requirements statement filing three times prior to the filing of its November 5, 2002 rate application. The original April 1, 2001 annual statement filing showed a loss ratio of 86.14% on the direct pay lines of business (HMO and POS in-network). The loss ratio report, filed May 1, 2002, reflected a combined loss ratio of 181.98% on the direct pay line of business and. the October 24, 2002 amended filing; the last filing prior to the November 5, 2002 rate application, showed a loss ratio of 118.38%.

In response to the examiner's questions regarding the sources of the data supporting each of the statutory filings, UHC stated that the same underlying data was used in its financial statement presentation, loss ratio reports and to develop the premium rates. However, the significant inconsistencies noted between the loss ratios as indicated by the results reported in the filed financial statement and the filed loss ratio reports call into question the size and frequency of the rate increases filed by UHC during this period.

Recommendations regarding the need to file accurate financial statement and loss ratio filings have been made earlier herein.

The following chart is a comparison of the loss ratios as presented in the original annual statement filing, the October 24, 2002 amended (third revision) annual statement filing, 2001 Loss Ratio Report and the 2001 revised Loss Ratio Report submitted April 3, 2003.

Comparison of Direct Pay Loss Ratios

Line of Business	Original 2001 annual statement filing	Revised 2001 annual statement filed October 24, 2002	2001 Loss Ratio Report	2001 revised Loss Ratio Report
HMO	88.12%	132.17%	148.25%	103%
POS (In-Network)	82.19%	104.99%	249.08%	143%
HMO & POS (combined)	86.14%	118.38%	181.98%	118%

The 2001 Annual Statement was re-filed on March 12, 2003 (5th revision) and the 2002 quarterly statements were re-filed on May 1, 2003. The data contained in the most recent filing in March of 2003 showed a combined loss ratio of 116.14%. The statements are currently under review by the Health Bureau's Company Regulatory Unit.

Discrepancies between the annual statement filings and the loss ratio report, although not to the same degree, were noted on the small and large group lines of business.

UHC subsequently withdrew the November 5, 2002 filing for its direct pay policyholders.

It is recommended that UHC's filed rate applications for rate changes be consistent with the filed financial statements and loss ratio reports and that the actuary conduct sufficient reviews, including a review of the results set forth on the latest available financial statement before certifying the rate application.

5. UNDERWRITING AND RATING

A targeted review was performed of UHC's rating practices relative to its community rated policies. Included in this review were direct pay, small group and large group policies. A limited review of large group experience rated policies was also performed.

Section 4308(b) of the New York Insurance Law requires that companies only charge those rates that are approved by the Department. Section 4308(g) of the Insurance Law allows health care companies to file rate increases and decreases with the Department ("file and use"), in lieu of obtaining the Superintendent's prior approval prior to the implementation of such rates. Section 4308(g)(2) requires health care companies availing themselves of the "file and use" option to notify policyholders of rate increases 30 days prior to implementation.

The review initially focused on the UHC's compliance with Section 4308(g) as it pertained to "file and use" submissions to be effective in the third quarter of 2002 and the first quarter of 2003. Specifically, the examiners tested whether UHC was charging the filed rates and had given policyholders the required 30-day notification prior to any rate increase. The scope of the examination was subsequently expanded to include general compliance with Section 4308(b) of the New York Insurance Law for all community rated products that renewed between January 1, 2002 through March 31, 2003. The review encompassed the various tiers (e.g. individual, husband/wife, parent/child, family) and geographical rating regions of UHC's community rated policies.

Section 4317 of the New York Insurance Law requires individual and small group insurance policies to be community rated and allows for rating variations according to a tier structure and geographic region.

UHC generally employs a four-tier rate structure however; certain contracts that were issued by UHC of Upstate New York were issued as and continue to have a two and three-tier rate structure. UHC maintains four different geographic rating regions. The premium rates for

UHC's Downstate and Long Island regions are rated identical. The following summarizes UHC's geographical rating structure:

1. Downstate - includes New York City and part of Westchester County.
2. Long Island – includes Nassau and Suffolk Counties
3. Mid-Hudson - includes five counties in the Mid-Hudson region and part of Westchester County.
4. Upstate – includes the counties serviced by UHC of Upstate New York, which consists of the counties of Cayuga, Herkimer, Madison, Oneida, Onondaga, and Oswego.

With the exception of certain large group contracts UHC utilizes quarterly rolling rates in accordance with Part 52.42 of Department Regulation 62 {11 NYCRR 52}. This rating mechanism allows for rates to escalate each calendar quarter. Groups or individuals enrolling or renewing in a particular calendar quarter will have their rates guaranteed for one year. UHC generally files for rate increases to be effective on the beginning of a calendar quarter.

Random samples of UHC's HMO and POS contracts were selected from each calendar quarter in the examination period for the various tier structures, and regions. Separate samples were selected for direct pay, small group and large group contracts. Except where noted, the examiners chose the samples from premium data provided by UHC.

A. Direct Payment

Random samples were selected from the population of 79 July (third quarter) 2002 renewals and 188 January (first quarter) 2003 renewals. The sample consisted of both the HMO and POS products and each of the tiers and regions. The following was noted from the review of the 3rd quarter renewals:

- On May 31, 2002, UHC sent a letter to all of their direct payment policyholders notifying them of a rate increase to be effective July 1, 2002. The examination review revealed that for nine of eleven items selected for review, the letter quoted the policyholder's existing rate in effect therefore, the prior renewal rate was incorrectly

- quoted as the new rate. Accordingly, policyholders were not properly notified of the rate increase. Additionally, UHC was unable to provide supporting documentation that the required notification was actually sent for two of the eleven policies sampled.

- In July 2002, UHC stated that it sent a second letter to notify the policyholders renewing in the third quarter of 2003, of an amended rate adjustment since it had decided to utilize its filed second quarter 2002 rates in lieu of implementing the submitted third quarter 2002 rate adjustment. The examination review revealed that again, the existing rate in effect was quoted in the notification letter. Further, UHC did not retain copies of the letters. UHC was able to produce the template used. The letter date was indicated as "July XX, 2002."

- UHC incorrectly charged the second quarter 2002 rate to members who enrolled or renewed during the third quarter of 2003. This was after its rate submission in May, and mailing of original notices to July renewals. UHC did not withdraw its submission, and new third quarter rates were placed on file by the Department on June 27, 2002. UHC should have then provided direct pay members renewing in August and September with the required 30-day notification of the rate increase to implement the new filed rates, and adjusted rates charged to July renewals to the new rates. UHC should not have sent a second notice indicating that it was implementing rates other than those resulting from its rate submission.

The following was noted from a review of the 1st quarter 2003 renewals:

- UHC sent out a letter notifying its direct payment policyholders of a 1st Quarter 2003 rate adjustment. However, UHC then decided not to implement this new rate adjustment and accordingly, a second letter was sent out. The second notification letter quoted the 4th quarter 2002 rate. As described below for 17 of the 20 policies sampled, the implemented rate was lower than the rate quoted in the notification letter. UHC did not retain copies of the second letter, but did retain the template.

- UHC did not implement the planned 1st Quarter rate increase because their rate application was withdrawn. UHC's intention was to implement the 4th quarter rate increase that had been previously placed on file.

- However, in seventeen of the twenty policies sampled, UHC implemented the 4th quarter 2001 rate rather than the 4th quarter 2002 rate.

As a result of the first sample's findings the examiner expanded the scope of the examination, and an additional review of 2002 direct pay renewals was performed for each calendar quarter.

From its premium database UHC provided two separate populations of direct pay policies: one consisting of upstate policies and the other of downstate policies. The Downstate file was composed of files from three rating regions: Downstate, Long Island and Mid-Hudson. Downstate and Long Island were combined for sampling purposes for the review since their filed rates were identical. The Upstate and Mid-Hudson rating regions were sampled and reviewed separately

The following chart shows the results of the review of the Upstate population of direct pay policies:

Upstate Rating Region

Quarter & Product	Total Population	Sample Size	Rating Error	Rating Error Percentage	No. of times notification letter was not provided or was incorrect
POS					
Q1 – 2002	16	2	0	0	1
Q2 – 2002	8	2	0	0	0
Q3 – 2002	7	2	2	100%	2
Q4 – 2002	8	6	6	100%	2
HMO					
Q1 – 2002	20	2	0	0	1
Q2 – 2002	12	2	0	0	0
Q3 – 2002	13	2	2	100%	1
Q4 – 2002	5	5	0	0	2
Total	89	23	10	43%	9

- UHC incorrectly implemented the 2nd quarter 2002 rate for POS policyholders renewing in the 4th quarter 2002.
- UHC incorrectly implemented the 2nd quarter 2002 rate in the 3rd quarter for HMO and POS policyholders.
- All rating errors were undercharges.

The Mid-Hudson and Downstate territories employ a four tier rating structure. The examiner randomly selected policies from each of the various tiers. The following is a chart showing the results of the review of the Mid-Hudson regions:

Mid-Hudson Rating Region

Quarter & Product	Total Population	Sample Size	Rating Error	Rating Error Percentage	No. of times notification letter was not provided or was incorrect
POS					
Q1 – 2002	8	4	2	50.00%	1
Q2 – 2002	11	9	0	0.00%	0
Q3 – 2002	11	5	5	100.00%	2
Q4 – 2002	12	5	1	20.00%	2
HMO					
Q1 – 2002	26	6	0	0.00%	1
Q2 – 2002	79	15	7	46.67%	0
Q3 – 2002	46	10	10	100.00%	4
Q4 – 2002	40	9	3	33.33%	1
Total	233	63	28	44.44%	11

- Sixteen of the twenty-eight errors were because UHC incorrectly rated certain policyholders as if he or she was a resident in the Mid-Hudson rating territory. UHC stated that the determination of the rating territory is by zip code. According to the insured's zip codes contained within the policies reviewed, these policyholders were residents of the Downstate region and should have been rated as such. Two of these errors occurred in the 1st quarter 2002 (including one that was charged the parent/child rate when the husband/wife rate should have been charged), seven occurred in the 2nd quarter 2002, three occurred in the 3rd quarter 2002, and four occurred in the 4th quarter 2002.

- The remaining twelve 3rd quarter renewal errors were comprised of cases where UHC incorrectly charged the second quarter rate.

- All rating errors were undercharges.

The following chart shows the results of the review of the Downstate/Long Island territory:

Downstate/Long Island Rating Region

Renewal Quarter	Total Population	Sample Size	Rating Error	Rating Error Percentage	No. of times notification letter was not provided or was incorrect
POS					
Q1 – 2002	291	15	0	0	9
Q2 – 2002	362	16	1	6.25%	0
Q3 – 2002	247	16	16	100.00%	9
Q4 – 2002	236	14	1	7.14%	11
HMO					
Q1 – 2002	451	16	0	0	6
Q2 – 2002	686	14	0	0	1
Q3 – 2002	559	12	12	100.00%	6
Q4 – 2002	515	15	1	6.67%	4
Total	3,347	118	31	26.67%	46

- UHC improperly billed the 2nd quarter 2002 filed rate for the entire policy year for all twenty-eight 3rd Quarter 2002 renewals sampled.
- The remaining three errors pertained to the policyholder being improperly charged the Mid-Hudson rate.
- All rating errors were undercharges.

It is noted that UHC uses a third party administrator (TPA) for the administration of its direct pay policies. Notwithstanding the billing functions performed by the TPA, UHC retains the ultimate responsibility to assure satisfactory administration of direct pay policies and compliance with the Insurance Law. In view of the findings it is apparent that UHC was not sufficiently monitoring the performance of its TPA.

For approximately one-third of the examiner's sample (204 contracts) the HMO either could not provide evidence that the required rate increase notification letter was mailed or the letter quoted the wrong rate.

It is recommended that UHC submit a plan for correcting all direct pay billing errors.

It is recommended that UHC take better care in the preparation and retention of correspondence notifying direct payment policyholders of rate adjustments and assure that the letters accurately quote the rate to be charged.

It is recommended that UHC comply with Section 4308(g) of the New York Insurance Law and only charge those rates, to its direct payment policyholders, that have been placed on file with the Department.

It is recommended that UHC management fulfill its responsibility for compliance with New York Insurance Law and Department rules and regulations as regards its rating practices via stronger oversight of its TPA.

B. Small group

Compliance was tested in each of the five quarters during the examination period. The small group sample results as presented, include both HMO and POS products. The 2002 population of HMO and POS polices was 512 and 566, respectively. The population of first quarter 2003 policies was limited to January renewals.

The following chart shows the results of the review of the small group sample:

Small Group

Renewal Quarter	Population	Sample Size	No. of Errors Found	Error Percentage Rate
POS				
Q1 – 2002	138	12	1	8.33%
Q2 – 2002	182	11	3	27.27%
Q3 – 2002	137	11	11	100.00%
Q4 – 2002	109	10	10	100.00%
Subtotal 2002	566	44	25	56.82%
Q1 – 2003	11	8	8	100.00%
Total POS	577	52	33	63.46%
HMO				
Q1 – 2002	124	16	15	93.75%
Q2 – 2002	149	14	6	42.86%
Q3 – 2002	102	11	11	100.00%
Q4 – 2002	134	11	11	100.00%
Subtotal 2002	509	52	43	82.69%
Q1 – 2003	28	8	7	87.50%
Total HMO	537	60	50	83.33%

- First Quarter 2002 - Sixteen errors found:
  - Fifteen errors resulted from the incorrect rate being loaded into the billing system.
  - One error occurred due to a policyholder being incorrectly charged for a dental coverage rider. UHC could not provide documentation pertaining to the rider.
- Second Quarter 2002 - nine errors found:
  - All nine errors resulted from the wrong rates being loaded.
- Third Quarter 2002 - twenty-two errors found:
  - Twenty errors resulted from the incorrect rate being loaded into the billing system.
  - UHC could not explain the reason for the discrepancy for the remaining two errors.
- Fourth Quarter 2002 – twenty-one errors found:
  - Twenty errors resulted from the incorrect rate being loaded into the billing system.
  - One was unexplained.

- First Quarter 2003 - fifteen errors found:
  - Twelve were because UHC used rates increased for a drug rider, which had not been included in the rates filed with the Department.
  - Three errors resulted from the incorrect rate being loaded into the billing system.

It is recommended that UHC comply with Section 4308(g) of the New York Insurance Law and only charge those rates relative to its small group business that are placed on filed with the Department.

C. Healthy New York

Premium rates of renewed policies during the year 2002 and the first quarter of 2003 were reviewed. The findings with regard to the Healthy NY sample are shown below:

Healthy New York

Renewal Year	Population	Sample Size	No. of Errors Found	Error Percentage Rate
2002	37	10	2	20.00%
2003	18	9	6	66.67%

- The two policies in error for renewal year 2002 were renewed at the wrong rate.
- All six of the errors occurring in 2003 were due to the wrong rate being charged.

UHC of NY administers the Healthy New York business on the same platform as the small groups. UHC of NY was unable to separate the Healthy New York from the small group business during the sampling process. Therefore fifteen Healthy New York policies were inadvertently selected in the random sampling of small group policies. These policies were also reviewed. Of the fifteen reviewed three errors were found.

It is recommended that UHC of NY comply with Section 4308(g) of the New York Insurance Law and only charge those rates relative to Healthy New York that are placed on file by the Department.

D. Large group

Random samples of UHC of NY's large group business were selected for review by rating region for groups renewing in each calendar quarter during the examination period. The population consisted of HMO contracts only, from the four rating regions: Downstate (New York City), Long Island, Mid-Hudson and Upstate. Due to the small population of large groups, there were several instances where the same group was selected for more than one region. Since the errors are calculated by sampled region this resulted in some cases of multiple errors for a single group.

The findings with regard to the large group HMO sample are shown below:

Large Group – HMO

Quarter	Population	Sample Size	No. of Rating Errors Found	Rating Error Percentage Rate	No. of times notification letter was not provided or was incorrect
Q1 – 2002	42	10	5	50.00%	5
Q2 – 2002	13	9	7	77.78%	7
Q3 – 2002	15	7	3	42.86%	2
Q4 – 2002	8	4	4	100.00%	4
Subtotal 2002	79	30	19	63.33%	18
Q1 – 2003	31	13	13	100.00%	5
Total	109	43	32	74.42%	23

- First Quarter - 2002

  - UHC could not explain the difference between the filed rate and the amount billed for the five errors found by the examiner. The examiner believes that these errors were probably attributable to the use of "guaranteed rates" (as discussed on page 22 of this Report).

  - In five of the ten items selected for review, UHC of NY could not produce evidence that the required thirty day rate adjustment notification letter was mailed to the group contract holders as required by Section 4308(g)(2) of the New York Insurance Law.

- Second Quarter 2002

  - Five errors involved the implementation of incorrect rates for two multi-region groups. A three-tier rating structure was used with both groups. The rates charged to members residing in the Long Island and New York City regions of one group were selected for review. For both regions the individual tier was overcharged by 4.04% and the family and individual plus one tier were undercharged by 4.08%. For the second group, the review included members residing in three rating regions: the Long Island, New York City and Mid-Hudson regions. The Long Island and New York City tier rates were each undercharged by 27.95%.

    With regard to the Mid-Hudson region:

    the individual tier was undercharged by 26.67%;
    the individual plus one tier was undercharged by 34.73%;
    the family tier was undercharged by 20.82%.

  - Two additional groups were not charged the filed rate. Both of these were Upstate region groups. The difference between the rate charged and the filed rate was less than $1 per month in each tier of both groups.

  - In all seven cases, UHC of NY could not produce evidence that the required rate adjustment notification letter was mailed.

- Third Quarter 2002

  There were three rating errors for three different groups as follows:

  - Mid-Hudson tier members of one group were incorrectly charged the Downstate (New York City) rate.

  - The remaining two groups were charged tier rates different then those on file

  - In two cases UHC of NY could not produce evidence that they mailed the required rate adjustment notification letter.

- Fourth Quarter 2002

  There were four rating errors for three different groups as follows:

  - For one group with a four-tier rating structure, the Long Island and New York City regions were sampled. UHC of NY undercharged each of the 4 tiers in both regions by 41% due to coding errors that caused the group to be rated using New Jersey rates.

- The members of one group residing in Long Island were under charged 1% for each tier.
- The other sampled group was in the Upstate region only and had membership across all tiers and was over charged by .04% for the individual, husband-wife and parent-child tiers. For the family tier, the members were under charged by .41%.
- In all cases UHC of NY could not produce evidence that they mailed the required rate adjustment notification letter.

- First Quarter 2003

There were thirteen rating errors for ten different groups as follows:

- Six errors related to three groups with members in two sampled rating regions. The groups were undercharged for each tier in both regions. The undercharges ranged from 1.21% to 1.38%
- Seven groups with members in one rating region were found to have tier rates different than those on file. The errors ranges from an undercharge of 11.37% to an overcharge of 35.95%
- For five of the groups selected, UHCof NY could not produce evidence that they mailed out the required rate adjustment notification letter as required by Section 4308(g)(2) of the New York insurance Law.

It is recommended that UHC of NY comply with Section 4308(g) of the New York Insurance Law and only charge those rates relative to its large group business that are placed on file with the Department.

It is recommended that UHC take better care in the preparation and retention of correspondence notifying large group policyholders of a rate adjustments and assure that the letters accurately quote the rate to be charged.

Of the errors noted above in 1st quarter 2003, the errors pertaining to seven of the groups were due to the fact that UHC implemented a rate based on a quoted estimate in advance of the renewal date. The quote was based on rates included in a February 28, 2002 rate filing. UHC made a subsequent rate filing on November 5, 2002 that changed the 1st quarter 2003 rates. The quote was made before the filing of the November 5, 2002 rate application which increased the

previously filed January 1, 2003 rates by 1.3% on average. The January 1, 2003 rates were implemented based on the original quote without considering the subsequent change.

In similar fashion UHC made two rate filings in the year 2001 and each filing contained large group HMO rates for the first quarter of 2002. On average the rates in the second filing resulted in rates that were 5.2% (on average) higher than the rates set forth in the earlier 2001 filing. Therefore groups renewing on January 1, 2002 who received a quote based on the earlier filing period paid on average 5.2% less than rate charged to other groups with the same renewal date.

In the absence of a "guaranteed rate" rider (as discussed below) all community rated groups must be charged the same rate. UHC practices are a violation of Section 4308(b) since the rate charged to certain groups was inadequate and the rate differentials on community rated business constitute a discriminatory rating practice.

Use of "guaranteed rates" is only permitted within the framework of Part 52.42 of Department Regulation No. 62, {11 NYCRR 52} which states, in part:

> "(b) Guaranteed rates. (1) An HMO may guarantee a subscriber a rate if such rate is based upon an approved rate at the effective date of the contract and satisfied the requirements of this subdivision. Any HMO that guarantees a rate without first obtaining an approved rate will be in violation of Section 4308 of the Insurance Law.
>
> (2) To guarantee rates the HMO must obtain the superintendent's approval for any contract provision, remitting agent agreement or rider which limits the HMO to adjustment of rates only on a policy anniversary date. This requirement applies to both group contracts and group remittance contracts
>
> (3) Permissible methods to guarantee the rates include the following:
> ...(a) By use of an approved rider or remitting agent agreement an HMO may establish an estimated annual subscriber rate to accommodate employers who prefer a level monthly premium payment for the contract year..."

A guaranteed rate rider, as described in Department Regulation No. 62 provides health insurers and HMOs with the flexibility to implement fixed rates based on quotes made well in advance of the contract effective date, and then settle any difference between the "guaranteed

rate" and the actual community rate during the corresponding period during the next contract year. UHC of NY does not use a guaranteed rate rider.

It is recommended that UHC of NY comply with Section 4308(b) of the New York Insurance Law and charge the same rate to all similarly situated large group community rated policyholders.

It is recommended that UHC of NY file a "guaranteed rate" rider in compliance with Department Regulation No. 62 Part 52.42.

It is recommended that UHC of NY recoup any difference between the quoted rate and the latest filed community rates.

6. BROKER'S COMMISSIONS

A review was performed of commissions paid to broker's on small business products. Section 4312(a)(1) of the New York Insurance states:

"...Commissions shall be included in the corporation's rate manual and rate filing..."

The examination findings reveal that UHC was using a commission plan that was not filed with the Department.

It is recommended that UHC file its commission plan with the Department in accordance with Section 4312(a) of the New York Insurance Law.

7. SUMMARY OF COMMENTS AND RECOMMENDATIONS

Respectfully submitted,

_____
Kathleen Grogan
Associate Insurance Examiner

STATE OF NEW YORK)
)SS
)
COUNTY OF NEW YORK)

Kathleen Grogan, being duly sworn, deposes and says that the foregoing report submitted by her is true to the best of her knowledge and belief.

_____
Kathleen Grogan

Subscribed and sworn to before me
this_____day of_____2003

Appointment No. 21951

STATE OF NEW YORK
INSURANCE DEPARTMENT

I, GREGORY V. SERIO , *Superintendent of Insurance of the State of New York, pursuant to the provisions of the Insurance Law, do hereby appoint:*

Kathleen Grogan

as a proper person to examine into the affairs of the

UNITED HEALTHCARE INSURANCE COMPANY OF NEW YORK

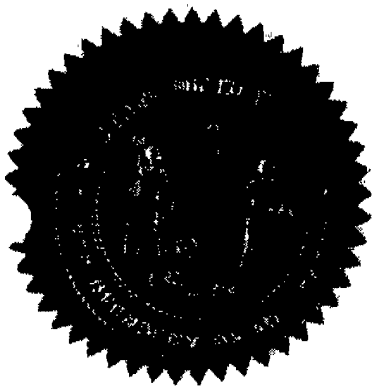
and to make a report to me in writing of the said

Company

with such information as she shall deem requisite.

In Witness Whereof, I have hereunto subscribed by the name and affixed the official Seal of this Department, at the City of New York.

this 15th *day of* November 2002



Gregory V. Serio
Superintendent of Insurance

Appointment No. 21952

STATE OF NEW YORK
INSURANCE DEPARTMENT

I, GREGORY V. SERIO , *Superintendent of Insurance of the State of New York, pursuant to the provisions of the Insurance Law, do hereby appoint:*

Kathleen Grogan

as a proper person to examine into the affairs of the

UNITED HEALTHCARE OF NEW YORK, INC.

and to make a report to me in writing of the said

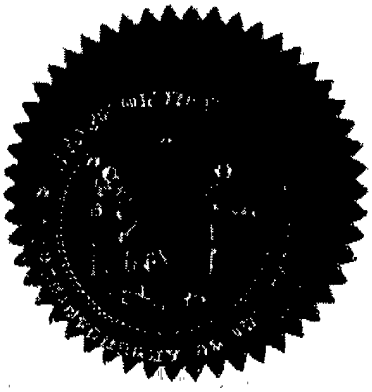
Company

with such information as she shall deem requisite.

In Witness Whereof, I have hereunto subscribed by the name and affixed the official Seal of this Department, at the City of New York.

this 15th *day of* November 2002

Gregory V. Serio
Superintendent of Insurance



REPORT ON

MARKET COMPLIANCE EXAMINATION

of

UNITEDHEALTHCARE OF NORTH CAROLINA, INC.

Greensboro, North Carolina

BY REPRESENTATIVES OF THE

NORTH CAROLINA DEPARTMENT OF INSURANCE

as of

September 28, 2000

Raleigh, North Carolina
September 28, 2000

Honorable James E. Long
Commissioner of Insurance
Department of Insurance
State of North Carolina
430 North Salisbury Street
Raleigh, North Carolina 27611

Honorable Commissioner:

Pursuant to your instructions and in accordance with North Carolina General Statutes (NCGS) 58-2-131 through 58-2-134 and 58-67-100, a Market Compliance Examination has been made of the North Carolina business and affairs of the Health Maintenance Organization (HMO)

UNITEDHEALTHCARE OF NORTH CAROLINA, INC.
Greensboro, North Carolina

hereinafter generally referred to as the Company, at its home office located at 2307 West Cone Boulevard, Greensboro, North Carolina. A report thereon is submitted as follows.

SCOPE OF EXAMINATION

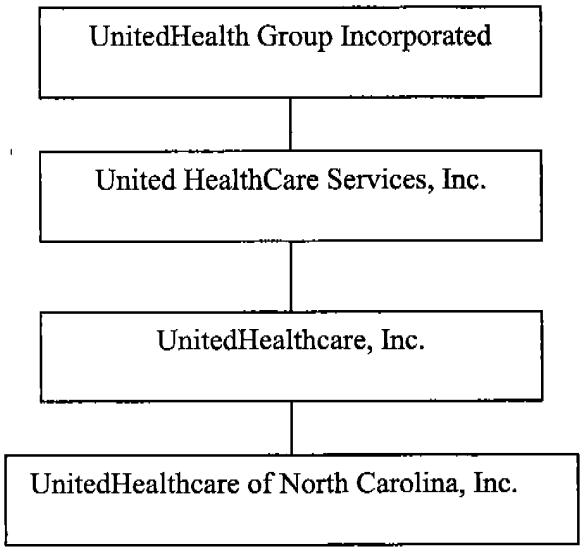
This examination commenced on September 5, 2000 and covered the period June 30, 1999 through September 28, 2000, with certain operations of the Company being reviewed through July 31, 2000. All comments made in this report reflect conditions observed during the period of the examination.

This examination was arranged and conducted by the North Carolina Department of Insurance (Department). It was made in accordance with Managed Care standards established by the Department and procedures established by the National Association of Insurance Commissioners and included reviews of records and such other procedures as were considered necessary under the circumstances.

COMPANY OVERVIEW

Corporate Structure

The Company is a wholly owned subsidiary of UnitedHealthcare, Inc. (the Parent Company), which is a wholly owned subsidiary of United HealthCare Services, Inc., which in turn is a wholly owned subsidiary of UnitedHealth Group Incorporated (formerly known as United HealthCare Corporation. UnitedHealth Group Incorporated is the ultimate Parent Company. The Company has an agreement with United HealthCare Services, Inc., a subsidiary of UnitedHealth Group Incorporated, in which certain administrative, consultative and other services are provided to the Company. Following is an excerpt from the current organizational structure:



UnitedHealth Group Incorporated indirectly holds greater than 10 percent ownership of the Company, a licensed North Carolina HMO. This arrangement qualifies UnitedHealth Group Incorporated as a holding company pursuant to NCGS 58-18 and 58-19 and UnitedHealthcare of North Carolina, Inc. has registered annually as required by NCGS 58-19-25.

History

The Company, formerly known as PHP, Inc., was acquired by United HealthCare Services, Inc. on March 2, 1996, and originally incorporated on March 12, 1985. On May 2, 1985, the Company received a preliminary Certificate of Authority (COA) from the Department to operate as an independent physician association model HMO in 6 counties. The preliminary COA was

valid until full COA was granted on May 21, 1985. On December 20, 1993, Physician's Health Plan of North Carolina, Inc. received approval to change its name to PHP, Inc. On March 19, 1996, the Department approved the acquisition of PHP, Inc. by United HealthCare Services, Inc. Effective January 1, 1997, PHP, Inc. changed its name to United HealthCare of North Carolina, Inc. Effective August 27, 1999, UnitedHealthCare of North Carolina, Inc. changed its name to UnitedHealthcare of North Carolina, Inc.

By order dated May 16, 2000, the North Carolina Department of Insurance approved the transfer of the Company's shares from United HealthCare Services, Inc. to UnitedHealthcare, Inc. effective June 30, 2000, resulting in UnitedHealthcare, Inc. becoming the sole shareholder of the Company.

On October 30, 1986, the Company received approval from the Department to expand its service area to a total of 22 counties, including the upper and lower regions of the Cape Fear Valley area of North Carolina. On March 15, 1993, the Department granted the Company permission to expand into the counties of western North Carolina. An additional 2-phase expansion, which was designed to ultimately cover the entire state of North Carolina, was approved by the Department on June 24, 1994.

On October 23, 1990 and March 6, 1995, the Company received approval from the Department to market point-of-service products for both the large and small group markets. The in-network portion of the benefit is underwritten by the Company and the out-of-network portion is underwritten by United HealthCare Insurance Company.

As of January 1, 1992, the Company was qualified to be a small group carrier, pursuant to Title 11 of the North Carolina Administrative Code (NCAC) Chapter 12, Section 1300.

Service Area

At the time of the examination the Company was licensed to do business in all 100 counties of North Carolina.

GENERAL ADMINISTRATION

Several deficiencies regarding the Company's general administration activities were noted during the Market Practices Examination and therefore were reviewed during the Market Compliance Examination. The results of that review are as follows:

1. During the Market Practices Examination it was noted that the Company was in apparent violation of NCGS 58-67-10, as it amended its articles of incorporation without notifying the Department.

   As of the Market Compliance Examination, the Company has not amended its articles of incorporation.

2. During the Market Practices Examination it was noted that the Company was in apparent violation of NCGS 58-67-10, as it did not notify the Department of the elections, appointments and resignations of 10 officers and board members.

   As of the Market Compliance Examination, the Company notified the Department of all elections, appointments and resignations of officers and board members in accordance with NCGS 58-67-10.

3. During the Market Practices Examination it was noted that the Company was in apparent violation of 11 NCAC 20.0602, as it did not notify the Department within 15 days of elections, appointments and resignations of 20 officers and board members.

   As of the Market Compliance Examination, the Company notified the Department within 15 days of all elections, appointments and resignations of officers and board members in accordance with NCGS 58-67-10.

4. During the Market Practices Examination it was noted that the Company was in apparent violation of NCGS 58-67-30, as it executed management agreements with United HealthCare Services, Inc., United Resource Networks, United Behavioral Systems, Inc., OPTUM Nurseline Services and United HealthCare Insurance Company prior to Department approval.

   As of the Market Compliance Examination, the Company has filed with and received approval from the Department for all management agreements currently in use, in accordance with NCGS 58-67-30.

5. During the Market Practices Examination it was noted that the Company was in apparent violation of NCGS 58-67-110, as it amended its reinsurance agreement prior to filing it with and receiving approval from the Department.

   As of the Market Compliance Examination, the Company has filed its reinsurance agreement with the Department for approval, in accordance with NCGS 58-67-110.

DELIVERY SYSTEM AND PROVIDER RELATIONS

Several deficiencies regarding the Company's delivery system and provider relations activities were noted during the Market Practices Examination and therefore were reviewed during the Market Compliance Examination. The results of that review are as follows:

1. During the Market Practices Examination it was noted that the Company was in apparent violation of 11 NCAC 19.0102, as it could not produce copies of some approved form provider contracts. The Department was unable to ascertain compliance with 11 NCAC 20.0201 for 43 provider contracts (43 percent) and 12 facility contracts (25 percent) executed after October 1, 1996.

   As of the Market Compliance Examination, the Company was able to produce all copies of approved form provider contracts, in accordance with 11 NCAC 19.0102.

2. During the Market Practices Examination it was noted that the Company was in apparent violation of 11 NCAC 20.0202, as it executed 52 provider contracts (52 percent) and 15 facility contracts (31 percent) that did not contain the required statutory provisions.

   As of the Market Compliance Examination, all executed provider contracts and facility contracts reviewed contained the required statutory provisions, in accordance with 11 NCAC 20.0202.

3. During the Market Practices Examination it was noted that the Company was in apparent violation of 11 NCAC 20.0203, as it made significant modifications to 33 provider contracts (33 percent) and 13 facility contracts (27 percent) prior to filing the contracts with the Department for approval.

   As of the Market Compliance Examination, the Department reviewed a random sample of 50 provider contracts from a total population of 2,269. The review revealed 6 (12 percent) of the files contained significant modifications of the approved form contracts, an apparent violation of 11 NCAC 20.0203.

   The Department also reviewed the total population of 47 facility contracts. The review revealed that none of the files contained significant modifications of the approved form contracts.

4. During the Market Practices Examination it was noted that the Company was in apparent violation of 11 NCAC 20.0201, as it executed 5 facility contracts (10 percent) after October 1, 1996 prior to receiving approval from the Department.

   As of the Market Compliance Examination, the Department reviewed the total population of 47 facility contract files, which revealed that 2 (4 percent) of the files were executed prior to

filing them with and receiving approval from the Department. The Company is reminded of the provisions of 11 NCAC 20.0201.

5. During the Market Practices Examination, a technical exception to 11 NCAC 20.0201 was noted, as the Company changed the form numbers on 11 (23 percent) approved form facility contracts and 2 (2 percent) provider contracts.

   As of the Market Compliance Examination, the Company had not changed the form numbers on any of the approved form facility contracts and provider contracts reviewed by the Department.

UTILIZATION MANAGEMENT

Several deficiencies regarding the Company's utilization management activities were noted during the Market Practices Examination and therefore were reviewed during the Market Compliance Examination. The results of that review are as follows:

1. During the Market Practices Examination it was noted that the Company could not produce a population of expedited appeals, documentation of notification to members regarding precertification determinations, or telephone accessibility reports, apparent violations of NCGS 58-50-61.

   As of the Market Compliance Examination, the Company was able to produce all requested records in accordance with NCGS 58-50-61.

2. During the Market Practices Examination it was noted that the Company could not provide utilization review records sufficient to document the review and decision in 18 (18 percent) precertification review files, an apparent violation of NCGS 58-50-61.

   As of the Market Compliance Examination, the Department reviewed a random sample of 50 precertification reviews from the total population of 2,901. This review revealed that notification was greater than 3 business days in 1 file (2 percent) and 1 additional file (2 percent) did not contain a notification letter, apparent violations of NCGS 58-50-61.

3. During the Market Practices Examination it was noted that the Company did not maintain sufficient documentation for utilization review records in 81 (81 percent) concurrent review files, an apparent violation of NCGS 58-50-61.

   As of the Market Compliance Examination, the Department reviewed a random sample of 100 concurrent review files from the total population of 5,855. This review revealed that in 4 files (4 percent) notification occurred in greater than 3 business days, an apparent violation of NCGS 58-50-61.

4. During the Market Practices Examination it was noted that the Company did not provide written notification to members of noncertification decisions within 5 business days of the determination in 7 (14 percent) retrospective review files, an apparent violation of NCGS 58-50-61.

   As of the Market Compliance Examination, the Department reviewed a random sample of 50 retrospective review files from the total population of 938. The Company included 8 invalid records, which reduced the sample size to 42. Upon review of the remaining 42 files the following issues were noted as apparent violations of NCGS 58-50-61:

   - In 4 files (10 percent) no notifications were documented.
   - In 1 file (2 percent) insufficient documentation was maintained to determine compliance.
   - In 1 file (2 percent) notification was not provided within 30 days.

5. During the Market Practices Examination it was noted that utilization review records did not contain sufficient documentation to demonstrate compliance with the notification requirements in 4 (8 percent) appeals of noncertifications, and members were not sent written notification identifying the coordinator of the appeals process within 3 business days in 8 (16 percent) appeals of noncertifications, apparent violations of and NCGS 58-50-61.

   As of the Market Compliance Examination, the Department reviewed the total population of 4 noncertification appeals. This review revealed the following issues which were noted as apparent violations of NCGS 58-50-61:

   - In 2 files (50 percent) the doctor reviewing the appeal was the same reviewer of the initial noncertification. Additionally, 1 of these files did not contain an acknowledgement letter.
   - In 1 file (25 percent) the decision notification letter did not contain all required components.
   - In 1 file (25 percent) the acknowledgement letter was not sent in 3 business days and the review was not completed within than 30 days.

QUALITY MANAGEMENT

Several deficiencies regarding the Company's quality management activities were noted during the Market Practices Examination and therefore were reviewed during the Market Compliance Examination. The results of that review are as follows:

1. During the Market Practices Examination it was noted that the Company was in apparent violation of NCGS 58-50-62, as review of quality of care complaints was not completed within 30 days of receipt in 6 (12 percent) files reviewed.

   As of the Market Compliance Examination, the Department reviewed the total population of 5 quality of care complaints. The review revealed that 2 (40 percent) quality of care complaints were not completed within 30 days of receipt, an apparent violation of NCGS 58-50-62.

2. During the Market Practices Examination it was noted that the Company was in apparent violation of NCGS 58-50-62, as acknowledgment letters sent to members who initiated quality of care complaints in 7 (14 percent) files reviewed did not contain all required statutory provisions.

   As of the Market Compliance Examination, the Department reviewed the total population of 5 quality of care complaints. This review revealed that 1 (20 percent) quality of care complaint contained an acknowledgment letter which was sent in greater than 3 business days, an apparent violation of NCGS 58-50-62.

PROVIDER CREDENTIALING

Several deficiencies regarding the Company's credentialing activities were noted during the Market Practices Examination and therefore were reviewed during the Market Compliance Examination. The results of that review are as follows:

1. During the Market Practices Examination the Company was in apparent violation of 11 NCAC 20.0404 and 20.0405, as all required documentation was not maintained in 14 (14 percent) provider files reviewed.

   As of the Market Compliance Examination, the Department reviewed a random sample of 50 provider credentialing files from a total population of 2,269. The review revealed that all provider credentialing files contained the required documentation, in accordance with 11 NCAC 20.0404 and 20.0405.

2. During the Market Practices Examination the Company was in apparent violation of 11 NCAC 20.0409, as it listed 3 (3 percent) providers and 1 (3 percent) facility in the provider directory prior to completion of the credentialing process.

   As of the Market Compliance Examination, the Company did not list any providers or facilities in the provider directory prior to completion of the credentialing process, in accordance with 11 NCAC 20.0409.

3. During the Market Practices Examination the Company was in apparent violation of 11 NCAC 20.0404 and 20.0405, as documentation sufficient to evidence that information had been obtained and verified was not maintained in 19 (40 percent) facility files reviewed.

   As of the Market Compliance Examination, the Department reviewed the total population of 43 facility credentialing files, which revealed that 1 (2 percent) file did not contain evidence of the facility's Medicare or Medicaid certification, an apparent violation of 11 NCAC 20.0404 and 20.0405. Of the 31 facilities due for recredentialing during the examination period, 6 (14 percent) facility credentialing files revealed that recredentialing was not conducted within a 3 year time period, an apparent violation of 11 NCAC 20.0407.

CLAIMS ADMINISTRATION

Several deficiencies regarding the Company's claims administration activities were noted during the Market Practices Examination and therefore were reviewed during the Market Compliance Examination. The results of that review are as follows:

1. During the Market Practice Examination it was noted the Company was in apparent violation of 11 NCAC 4.0319, as members were not sent notice of claims processed in excess of 45 days in 100 (100 percent) claims reviewed.

   As of the Market Compliance Examination, the Department reviewed a sample of 50 claims not processed within 45 days, from the total population of 2,092. The following issues were identified from this review:

   There were 10 (20 percent) instances in which a claims status report was sent to the insured, but not within 45 days, again an apparent violation of 11 NCAC 4.0319. Also, the Company could not produce a copy of the original claim submitted in 1 instance. The Company is reminded of the provisions of 11 NCAC 19.0105.

2. During the Market Practices Examination it was noted that the Company was in apparent violation of NCGS 58-3-172, as members were not sent claim denial notifications for 52 (52 percent) denied claims reviewed.

   As of the Market Compliance Examination, the Department reviewed a sample of 100 denied claim line items from a total population of 557,447. This review revealed that for 70 (70 percent) denied claim line items, written notifications of denied claims were not sent to members. The Company is again in apparent violation of NCGS 58-3-172. It was also noted that the Company does not send notices of denied claims to members at the time an emergency services claim is denied, pending submission of medical records. The Department requires that the Company revise its policies and procedures to reflect that members will be sent notice when claims are denied, pending submission of medical records.

MEMBER SERVICES

Several deficiencies regarding the Company's member services activities were noted during the Market Practices Examination and therefore were reviewed during the Market Compliance Examination. The results of that review are as follows:

1. During the Market Practices Examination it was noted that the Company was in apparent violation of NCGS 58-50-62, as the Company's member grievance policy did not contain a provision that acknowledgment letters to be sent to members include all required provisions of NCGS 58-50-62.

   As of the Market Compliance Examination, the Company's member grievance policy contains a provision that acknowledgment letters to be sent to members include all required provisions of NCGS 58-50-62. However, the following issues were noted as apparent violations of NCGS 58-50-62:

   - The Company's policy CS 13.12 dated July 12, 1999 does not include a provision that includes a statement of the members right to a second-level review in the decision notification letter. This policy also allows the grievance to be resolved in 30 working days rather than 30 calendar days.

   - The Company's policy CS 13.3 dated July 17, 2000 allows 45 days to resolve a grievance instead of completing the overall grievance review in 30 days.

2. During the Market Practices Examination the Company was in apparent violation of NCGS 58-50-62, as reviews of member grievances revealed that the Company did not send an acknowledgment letter to 1 (2 percent) member; acknowledgment letters were sent in greater than 3 business days to 2 (4 percent) members; and 13 (26 percent) acknowledgment letters did not contain all required statutory provisions.

   As of the Market Compliance Examination, the Department reviewed a random sample of 50 member grievances from a total population of 200 received by the Company during the examination period. The review revealed the following issues which are apparent violations of NCGS 58-50-62:

   - Acknowledgment letters were not sent within 3 business days in 11 (22 percent) files.

   - Decision notification letters did not contain a statement of the member's right to a second-level grievance review in 11 (22 percent) files.

   - Grievances were resolved in greater than 30 days in 5 (10 percent) files.

3. During the Market Practices Examination it was noted that the Company was in apparent violation of NCGS 58-39-55, as it did not file its adverse underwriting denial notification letter for approval prior to use.

As of the Market Compliance Examination, the Company has filed its adverse underwriting denial notification and received approval from the Department as of May 5, 1999, in accordance with NCGS 58-39-55.

SALES AND MARKETING

Several deficiencies regarding the Company's sales and marketing activities were noted during the Market Practices Examination and therefore were reviewed during the Market Compliance Examination. The results of that review are as follows:

1. During the Market Practices Examination it was noted that the Company was in apparent violation of 11 NCAC 12.0525, as its Choice HMO and Choice Plus product description brochures did not include the source of quoted statistical information, an apparent violation of 11 NCAC 12.0525.

   As of the Market Compliance Examination, all product description brochures in use during the examination period were found to be compliant with North Carolina laws and regulations.

2. During the Market Practices Examination it was noted that the Company was in apparent violation of 11 NCAC 12.0533, as it did not maintain a complete file demonstrating the manner and extent of distribution of all advertising produced for the entire examination period.

   As of the Market Compliance Examination, the advertising file was reviewed and was found to be complete, demonstrating the manner and extent of distribution of all advertising produced for the examination period, in accordance with 11 NCAC 12.0533.

PREMIUM RATE SETTING AND UNDERWRITING

Several deficiencies regarding the Company's premium rate setting and underwriting activities were noted during the Market Practices Examination and therefore were reviewed during the Market Compliance Examination. The results of that review are as follows:

1. During the Market Practices Examination it was noted that the Company did not produce all employer group underwriting files on the first day of the examination, an apparent violation of 11 NCAC 19.0106.

   As of the Market Compliance Examination, all employer group underwriting files were produced as requested by the Department, in accordance with 11 NCAC 19.0106.

2. During the Market Practices Examination it was noted that the Company did not use its filed and approved rating methodology, as an unapproved chemical dependency factor was applied to the 1998 rate calculations for 36 (36 percent) small groups, an apparent violation of 11 NCAC 16.0603; sufficient documentation to justify the underwriter's judgment factor utilized in the rate development of 24 (24 percent) small group cases was not maintained, an apparent violation of 11 NCAC 19.0104; and sufficient documentation of the rating methodology applied to 1 (1 percent) 1995 small group case was not maintained leaving the Department unable to ascertain compliance, an apparent violation of NCGS 58-67-50.

   As of the Market Compliance Examination, the Department reviewed a random sample of 100 employer group underwriting files from a total population of 5,059. All files contained sufficient documentation of the rating factors and methodology applied and were processed pursuant to the Company's filed and approved rating methodology, in accordance with 11 NCAC 16.0603, 19.0104 and NCGS 58-67-50.

DELEGATED OVERSIGHT

Several deficiencies regarding the Company's delegated activities were noted during the Market Practices Examination and therefore were reviewed during the Market Compliance Examination. The results of that review are as follows:

1. During the Market Practices Examination it was noted that the Company was in apparent violation of 11 NCAC 20.0601, as it did not file required notices of the addition of 3 intermediary organizations within 30 days of execution of the agreements.

   As of the Market Compliance Examination, the Department reviewed the timeliness of notifications regarding additions or terminations of intermediaries. The Company did not file required notice of the termination of 1 intermediary (Gateway Physician Affiliates, Inc.) within 30 days after termination of the contract, an apparent violation of 11 NCAC 20.0601.

2. During the Market Practices Examination it was noted that the Company was in apparent violation of 11 NCAC 20.0204, as it did not certify that contracts used by 3 intermediary organizations complied with the provisions of 11 NCAC 20.0202, nor did it certify within 30 days that contracts used by 6 intermediary organizations complied with the provisions of 11 NCAC 20.0202.

   As of the Market Compliance Examination, the Company has filed the required certifications for all of its contracted intermediary organizations, in accordance with 11 NCAC 20.0204.

3. During the Market Practices Examination it was noted that the Company was in apparent violation of 11 NCAC 20.0203, as it made significant modifications to 9 intermediary agreements prior to receiving the Department's approval.

As of the Market Compliance Examination, the Company filed contract amendments with and received approval from the Department in order to bring these intermediary agreements into compliance with 11 NCAC 20.0204.

4. During the Market Practices Examination it was noted that the Company was in apparent violation of 11 NCAC 20.0201, as it did not file contract forms for 12 intermediary organizations prior to executing the agreements.

   As of the Market Compliance Examination, all intermediary agreements reviewed during this examination were executed on contract forms approved by the Department, in accordance with 11 NCAC 20.0201.

5. During the Market Practices Examination it was noted that the Company was in apparent violation of 11 NCAC 20.0410, as it did not receive updated lists of additions and deletions to the provider network of United Resource Networks at least quarterly.

   As of the Market Compliance Examination, the Company received quarterly updates of additions and deletions to the provider network of United Resource Networks, in accordance with 11 NCAC 20.0410.

SUMMARY

The Market Compliance Examination of UnitedHealthcare of North Carolina, Inc. revealed the following apparent violations:

Delivery System and Provider Relations

1. The Company is again in apparent violation of 11 NCAC 20.0203, as 6 (12 percent) of the provider contract files contained significant modifications of the approved form contracts.

Utilization Management

2. The Company is again in apparent violation of NCGS 58-50-61, as notification of a precertification review decision was sent in greater than 3 business days in 1 file (2 percent) and 1 additional file (2 percent) did not contain a notification letter.

3. The Company is again in apparent violation of NCGS 58-50-61, as 4 (4 percent) concurrent review files revealed that notification of the decision occurred in greater than 3 business days.

4. The Company is again in apparent violation of NCGS 58-50-61, as retrospective review files revealed that no notifications were documented in 4 (10 percent) files; insufficient documentation was maintained to determine compliance in 1 file (2 percent); and the notification was not provided within 30 days in 1 file (2 percent).

5. The Company is again in apparent violation of NCGS 58-50-61, as review of noncertification appeals revealed that the doctor reviewing the appeal was the same reviewer of the initial noncertification in 2 files (50 percent). Additionally, 1 of these files did not contain an acknowledgement letter; the decision notification letter did not contain all required components in 1 file (25 percent); and the acknowledgement letter was not sent within 3 business days, nor was the appeal resolved within 30 days in 1 file (25 percent).

Quality Management

6. The Company is again in apparent violation of NCGS 58-50-62, as review of quality of care complaints revealed that 2 (40 percent) were not completed within 30 days of receipt and 1 (20 percent) contained an acknowledgment letter which was not sent within 3 business days.

Provider Credentialing

7. The Company is again in apparent violation of 11 NCAC 20.0404 and 20.0405, as review of facility credentialing files revealed that 1 (2 percent) file did not contain evidence of the facility's Medicare or Medicaid certification. The Company is also in apparent violation of 11 NCAC 20.0407, as 6 (14 percent) facility credentialing files revealed that recredentialing was not conducted within a 3 year time period.

Claims Administration

8. The Company is again in apparent violation of 11 NCAC 4.0319, as a claims status report was not sent to the insured within 45 days for 10 (20 percent) claims processed in excess of 45 days of initial receipt.

9. The Company is again in apparent violation of NCGS 58-3-172, as members were not sent claim denial notifications for 70 (70 percent) denied claims reviewed.

Member Services

10. The Company is again in apparent violation of NCGS 58-50-62, as the Company's member grievance policies and procedures do not include a provision that states the member's right to a second-level review in the decision notification letter; allows the grievance to be resolved in 30 working days rather than 30 calendar days; and allows 45 days to resolve a grievance instead of completing the overall grievance review in 30 days.

11. The Company is again in apparent violation of NCGS 58-50-62, as reviews of member grievances revealed that acknowledgment letters were not sent within 3 business days in 11 (22 percent) files; decision notification letters did not give members their right to a second-level grievance in 11 (22 percent) files; grievances were not resolved within 30 days in 5 (10 percent) files.

Delegated Oversight

12. The Company is again in apparent violation of 11 NCAC 20.0601, as it did not file required notice of the termination of 1 intermediary within 30 days after termination of the contract.

In addition to the apparent violations listed above, the following items have been noted:

1. The Company is reminded of the provisions of 11 NCAC 20.0201, as 2 (4 percent) of the facility contract files were executed prior to filing them with and receiving approval from the Department.

2. The Company is reminded of the provisions of 11 NCAC 19.0105, as the Company could not produce a copy of the original claim submitted in 1 (2 percent) instance in the sample of claims processed in excess of 45 days.

TABLE OF STATUTES AND RULES

Statute/Rule	Title
NCGS 58-2-131	Examinations to be made; authority, scope, scheduling, and conduct of examinations.
NCGS 58-2-132	Examination reports.
NCGS 58-2-133	Conflict of interest; cost of examinations; immunity from liability.
NCGS 58-2-134	Cost of certain examinations.
NCGS 58-3-172	Notice of claim denied.
NCGS 58-18	Promoting and Holding Companies.
NCGS 58-19	Insurance Holding Company System Regulatory Act.
NCGS 58-19-25	Registration of insurers.
NCGS 58-39-55	Reasons for adverse underwriting decisions.
NCGS 58-50-61	Utilization review.
NCGS 58-50-62	Insurer grievance procedures.
NCGS 58-67-10	Establishment of health maintenance organizations.
NCGS 58-67-30	Management and exclusive contracts.
NCGS 58-67-50	Evidence of coverage and premiums for health care services.
NCGS 58-67-100	Examinations.
NCGS 58-67-110	Protection against insolvency.
11 NCAC 4.0319	Claims practices: life: Accident and health insurance
11 NCAC 12.0525	Accident and health advertising: use of statistics

Statute/Rule	Title
11 NCAC 12.0533	Accident and health advertising: advertising file
11 NCAC 12.1300	Small Employer Group Health Coverage
11 NCAC 16.0603	HMO rate filing data requirements
11 NCAC 19.0102	Maintenance of records
11 NCAC 19.0104	Policy records
11 NCAC 19.0105	Claim records
11 NCAC 19.0106	Records required for examination
11 NCAC 20.0201	Written contracts
11 NCAC 20.0202	Contract provisions
11 NCAC 20.0203	Changes requiring approval
11 NCAC 20.0204	Carrier and intermediary contracts
11 NCAC 20.0404	Application
11 NCAC 20.0405	Verification of credentials
11 NCAC 20.0407	Reverification of provider credentials
11 NCAC 20.0409	Records and examinations
11 NCAC 20.0410	Delegation of credential verification activities
11 NCAC 20.0601	Applications for modifications to service areas or product lines
11 NCAC 20.0602	Written notice

CONCLUSION

An examination has been conducted on the market practices and affairs of UnitedHealthcare of North Carolina, Inc., including analysis of certain operations of the Company for the period of June 30, 1999 through September 28, 2000.

In addition to the undersigned, Tanyelle Byrd, Julie Lugar and Lalita Wells participated in this examination and the preparation of this report.

Brian Goble, FLMI
Examiner-In-Charge
Managed Care and Health Benefits Division

I have reviewed this examination report and found that it meets the provisions for such reports as prescribed by this Division and the North Carolina Department of Insurance.

Nancy O'Dowd
Deputy Commissioner
Managed Care and Health Benefits Division

REPORT ON

MARKET CONDUCT EXAMINATION

of the

UNITED HEALTHCARE INSURANCE COMPANY

Hartford, Connecticut

BY REPRESENTATIVES OF THE

NORTH CAROLINA DEPARTMENT OF INSURANCE

as of

November 9, 2001

TABLE OF CONTENTS

Raleigh, North Carolina
November 9, 2001

Honorable James E. Long
Commissioner of Insurance
Department of Insurance
State of North Carolina
430 N. Salisbury Street
Raleigh, North Carolina 27603

Honorable Commissioner:

Pursuant to your instructions and in accordance with the provisions of North Carolina General Statute (N.C.G.S.) 58-2-131, a Market Conduct examination has been made of the North Carolina business of

UNITED HEALTHCARE INSURANCE COMPANY
(NAIC #79413)
Hartford, Connecticut

hereinafter generally referred to as the Company, at the North Carolina Department of Insurance Market Examinations offices located at 111 Seaboard Avenue, Raleigh, North Carolina. A report thereon is submitted as follows:

SCOPE OF EXAMINATION

This examination commenced on September 4, 2001 and covered the period of January 1, 1998 through December 31, 2000 with analyses of certain operations of the Company being conducted through November 9, 2001. The focus of this examination was only on Accident and Health North Carolina Indemnity business. All comments made in this report reflect conditions observed during the period of the examination.

The examination was arranged and conducted by the North Carolina Department of Insurance (Department). It was made in accordance with Market Conduct standards established by the Department and procedures established by the National Association of Insurance Commissioners (NAIC) and accordingly included tests of policyholder treatment, utilization review, marketing, underwriting, and claims practices.

COMPANY OVERVIEW

History and Profile

The Company was originally incorporated in Illinois as The Travelers Insurance Company of Illinois in 1972. The name was changed to The MetraHealth Insurance Company during 1994, at which time it was redomesticated to Connecticut. On October 2, 1995, 100 percent of The MetraHealth Companies, Inc. was purchased by United HealthCare Corporation. Effective January 1, 1997, The MetraHealth Insurance Company and United Health and Life Insurance Company, Minnesota insurance companies merged. As a result of the merger, the surviving entity, The MetraHealth Insurance Company, was renamed United HealthCare Insurance Company. On June 30, 2000, UnitedHealth Group (UnitedHealth) contributed all the shares of United HealthCare Insurance Company to its wholly owned subsidiary United HealthCare Services, Inc., who in turn contributed all the issued and outstanding shares of United HealthCare Insurance Company to its wholly owned subsidiary, Unimerica, Inc. As a result, the Company became a direct wholly owned subsidiary of Unimerica, Inc.

Company Operations and Management

The Company is licensed to write group accident and health business in the District of Columbia, the Virgin Islands, Puerto Rico, Guam, and all states except New York. The Company offers organized health systems point-of-service plans, preferred provider organizations, and managed indemnity programs.

The North Carolina total direct written premium for the past 3 years follows:

Line of Business	1998	1999	2000
Life	$ 46,589	$ 71	$ 56,182
Annuity	0	0	0
Accident & Health	168,295,851	170,380,063	180,928,297
Total	**$168,342,440**	**$170,380,134**	**$180,984,479**

The Company's direct written premium for the past 3 years follows:

	1998	1999	2000
Total Premium	$5,822,475,329	$5,958,095,437	$6,218,554,230
NC Premium as a Percentage of Total	2.89%	2.86%	2.91%

The Company reported no direct written Deposit Type Funds during the examination period.

Management Agreements

The Company reported no management agreements between affiliates or private contractors during the examination period.

Certificates of Authority

The Company is authorized to write life insurance including industrial sick benefit insurance, as well as accident and health insurance (cancellable and noncancellable) and annuities (excluding variable annuities) in accordance with the provisions of N.C.G.S. 58-7-15. The current certificate of authority for North Carolina is valid until June 30, 2002.

Reinsurance

The Company reported that there were no reinsurance agreements in effect in North Carolina during the examination period.

Disaster Recovery

The Company provided a copy of the UnitedHealth disaster recovery procedures (The Plan) for the Southbury, Connecticut Data Center managed by IBM Global Services (IGS) for UnitedHealth for review. The Plan provides specific instructions on steps to take during an emergency or disaster. The Southbury Data Center provides mission-critical resources to UnitedHealth through Unified Networking System (a computer operating system referred to as UNET) to IGS host systems. The primary recovery center for IGS is administered by IBM

Business Recovery Services (BRS) at Gaithersburg, Maryland. A secondary recovery site, should the primary site be unavailable, will be provided by BRS.

The Southbury Data Center is an IGS facility to which UnitedHealth outsources some of its data processing needs. Thus, incident identification, disaster declaration, disaster recovery efforts, and contingency and disaster recovery planning for this site include disaster recovery teams and management personnel from both companies.

The Plan is comprehensive in direction and content. The Plan is tested annually at the site's primary back-up facility or another facility that could demonstrate recoverability of UnitedHealth processing. The Plan is then revised where updates are appropriate.

Internal Audit Functions

The Company provided copies of all relevant internal audit reports for the examiners' review, as well as a copy of its internal audit procedures.

No specific Internal Audit Department exists at the Company or at the Health Plan level; although internal audit activities at the United HealthCare Group's (UHG) level often impact the high-risk areas for the individual health plans.

The internal audit function for all of UHG was outsourced beginning in 1999 to 2 audit firms. For each year's internal audit plan, Ernst & Young handles all of the Company's legal, regulatory, and compliance audits; and, Arthur Andersen handles all operational and financial audits. This structure has enabled the Company to call on the deep resources of these 2 international firms to accomplish appropriate audit staffing. All processes and/or functions within UHG are typically covered within a 2 to 3 year audit cycle. Specialists are utilized for the operational audits to provide the needed knowledge and expertise in the given area.

The auditors have direct access to senior management, the Board of Directors, the Audit Committee, and appropriate Company executives. The scope of internal audit activities is planned in advance with senior management and the Audit Committee. Final reports are

prepared on each audit, which include management responses and action plans. Tracking follow-up to determine completion may be assigned or may be the function of the Company's compliance area. In some cases, the internal audit team acts as an additional monitoring mechanism.

Third Party Administrators

The Company reported that it did not use the services of any third party administrators in North Carolina during the examination period.

POLICYHOLDER TREATMENT

Consumer Complaints

All consumer complaints from a population of 3 were reviewed for accuracy, adherence to Company guidelines, and compliance with North Carolina statutes and rules.

A chart of the consumer complaints by type follows:

Type	1998	1999	2000
Administration	1	0	0
Claims	1	1	0
Total	**2**	**1**	**0**

All complaints and inquiries, whether received by telephone or mail, were investigated and responded to by a letter of resolution at closure.

A review of the complaint register revealed that it complied with the provisions of Title 11 of the North Carolina Administrative Code, (NCAC), Chapter 19, Section 0103.

The average service time to respond to a Departmental complaint was 4 calendar days. The Company was deemed to be in compliance with the provisions of 11 NCAC 1.0602. A chart of the Company's response time follows:

Service Days	Number of Files	Percentage of Total
1 - 7	3	100.0
Total	**3**	**100.0**

UTILIZATION REVIEW

Utilization Review and Grievance Procedures

The provisions of N.C.G.S. 58-50-61 and 58-50-62 require insurers, that offer health benefit plans, to establish and maintain appeal and grievance processes for handling insureds' complaints and requests for appeal on a utilization review decision. The policies and procedures that support these processes must meet detailed requirements set out in these 2 laws. The examiners did not review the Company's grievance processes because the Department's Managed Care and Health Benefits Division reviewed this portion of Company operations in a separate examination conducted in the Summer of 2000. That report was issued on September 28, 2000.

Prospective Reviews

All prospective reviews from a population 38 were reviewed for accuracy, adherence to Company guidelines, and compliance with North Carolina statutes and rules.

No irregularities, adverse trends, or unfair trade practices were perceived in this section of the examination.

The average service time to respond to a review was 2 calendar days.

Concurrent Reviews

A random sample of 50 concurrent reviews from a population of 127 was reviewed for accuracy, adherence to Company guidelines, and compliance with North Carolina statutes and rules.

Two concurrent review files (4.0 percent error ratio) were considered invalid receipts as the file did not contain evidence that a concurrent review was performed during the examination

period. The Company was reminded of the provisions of N.C.G.S. 58-2-131, 58-2-185, and 11 NCAC 19.0106. The review was based on the remaining 48 concurrent reviews.

Forty-eight concurrent review files (100 percent error ratio) did not contain evidence that the concurrent determinations were communicated to the provider within 3 business days after receiving all necessary information about the admission, procedure, or health care service. The Company was deemed to be in apparent violation of the provisions of N.C.G.S. 58-50-61.

The average service time could not be calculated because the Company acknowledged that the files did not contain sufficient evidence that the concurrent determinations were communicated to the provider.

Retrospective Reviews

All retrospective reviews from a population of 1 were reviewed for accuracy, adherence to Company guidelines, and compliance with North Carolina statutes and rules.

One retrospective review file (100 percent error ratio) did not contain evidence that a noncertification letter was sent to the insured and provider within 5 business days after making the noncertification. The Company was deemed to be in apparent violation of the provisions of N.C.G.S. 58-50-61.

The average service time to process a retrospective review could not be calculated because the Company did not send noncertification letters to the insured and provider. The Company informed the examiners that in December 2000 they identified the need to enhance system capabilities and develop departmental procedures in order to ensure compliance.

Maternity Length of Stay

The Company provided a copy of their report regarding maternity length of stay for the examiners' review. The report was deemed to be in compliance with the provisions of N.C.G.S. 58-3-169 that requires the insurer to provide coverage for a minimum of 48 hours after a vaginal delivery and a minimum of 96 hours following a cesarean section delivery. A report

reflecting the average length of stay for maternity admissions during the examination period revealed the following:

- Vaginal deliveries average length of stay = 2.3 days
- Cesarean section deliveries average length of stay = 3.6 days

Standard Non-Expedited Appeals

All standard non-expedited appeals from a population of 3 were reviewed for accuracy, adherence to Company guidelines, and compliance with North Carolina statutes and rules.

One standard appeal file (33.3 percent error ratio) was considered an invalid receipt as it referenced a provider/claims coding error and not a utilization review appeal. The Company was deemed to be in apparent violation of the provisions of N.C.G.S. 58-2-131, 58-2-185, and 11 NCAC 19.0106. The review was based on the remaining 2 standard appeals.

One standard appeal file (50.0 percent error ratio) did not contain a copy of the acknowledgement letter and the examiner could not determine acknowledgement to the covered person was within 3 working days of the request for appeal. The Company was deemed to be in apparent violation of the provisions of N.C.G.S. 58-50-61. In December 2000, the Company identified the need to develop departmental procedures specific to North Carolina law to ensure compliance with this statute.

The average service time to respond to an appeal was 2 calendar days.

Expedited Noncertification Appeals

The Company informed the examiners that they did not process any Expedited Noncertification Appeals in North Carolina during the examination period.

MARKETING

Certificate of Compliance - Advertising

The Company provided a copy of its Certificate of Compliance - Advertising for the year 2000 as required by the provisions of 11 NCAC 12.0431 and 12.0534. The Company informed the examiners that it did not engage in advertising activity in 1998 and 1999.

Agency Management

New business is distributed through an integrated sales force in UnitedHealth, with sales teams focusing on different segments. The sales force was established shortly after the former MetraHealth Insurance Company was acquired by UnitedHealth to have a consistent and unified image in the marketplace. Sales representatives are trained in selling all products to provide customers with solutions rather than products.

Approximately 1,755 active agents in the state of North Carolina represent the Company.

Appointment and Termination of Agents

A random sample of 50 agent appointments from a population of 1,629 was reviewed for accuracy, adherence to Company guidelines, and compliance with North Carolina statutes and rules.

Two agent appointment files (4.0 percent error ratio) were considered invalid receipts as they did not represent appointments during the examination period. The Company was reminded of the provisions of N.C.G.S. 58-2-131, 58-2-185, and 11 NCAC 19.0106. The review was based on the remaining 48 agent appointment files.

Two agent appointment files (4.2 percent error ratio) did not contain a copy of the Appointment of North Carolina Agent form and the examiner was unable to determine that the Department was notified within 30 days of the agent's appointment date. The Company was reminded of the provisions of N.C.G.S. 58-33-40 and 11 NCAC 6A.0412.

Forty-eight agent appointment files (100 percent error ratio) did not contain evidence that a due diligence background check was performed on the agents prior to appointment. The Company was deemed to be in apparent violation of the provisions of N.C.G.S. 58-33-30 and 11 NCAC 6A.0412.

A random sample of 50 terminated agent files from a population of 170 was reviewed for accuracy, adherence to Company guidelines, and compliance with North Carolina statutes and rules.

Two agent termination files (4.0 percent error ratio) were not provided. The Company was reminded of the provisions of 11 NCAC 19.0102 and 19.0106. The review was based on the remaining 48 agent termination files.

Fifteen agent termination files (31.3 percent error ratio) were considered invalid receipts as the agents were not terminated with the Company under review or the agents were not terminated during the examination period. The Company was deemed to be in apparent violation of the provisions of N.C.G.S. 58-2-131, 58-2-185, and 11 NCAC 19.0106. The review was based on the remaining 33 agent termination files.

Twenty-six agent termination files (78.8 percent error ratio) did not contain documentation that the agent was notified of termination. The Company was deemed to be in apparent violation of the provisions of N.C.G.S. 58-33-55.

Sales and Advertising

A review of the sales and advertising materials furnished by the Company was completed. No irregularities, adverse trends, or unfair trade practices were perceived in this section of the examination.

Policy Forms and Filings

All policy forms in use during the examination period were compared with a list of approved policy forms from the Department pursuant to the provisions of 11 NCAC 12.0307.

No irregularities, adverse trends, or unfair trade practices were perceived in this section of the examination.

UNDERWRITING

Small Employer Group Issued

All small employer groups from a population of 16 were reviewed for accuracy, adherence to Company guidelines, and compliance with North Carolina statutes and rules.

Five small group files (31.2 percent error ratio) did not contain the group application or the insureds' applications. The Company was deemed to be in apparent violation of the provisions of 11 NCAC 19.0102.

Five small group files (31.2 percent error ratio) contained evidence that the agent solicited the business prior to appointment or was not appointed. The Company was deemed to be in apparent violation of the provisions of N.C.G.S. 58-33-25 and 58-33-40.

Small Employer Group Issued Basic and Standard

The Company informed the examiners that they did not process any Small Employer Group Issued Basic and Standard in North Carolina during the examination period.

CLAIMS PRACTICES

Group Major Medical Claims Paid

A random sample of 100 claims from a population of 10,466 was reviewed for accuracy, adherence to Company guidelines, and compliance with North Carolina statutes and rules.

Six claims files (6.0 percent error ratio) were considered invalid receipts as 1 claim represented a self-funded plan and 5 claims were not paid during the examination period. The Company was reminded of the provisions of N.C.G.S. 58-2-131, 58-2-185, and 11 NCAC 19.0106. The review was based on the remaining 94 claims files.

Nine claims (9.6 percent error ratio) were not processed within 30 days and the Company failed to acknowledge receipt of the claim. The Company was deemed to be in apparent violation of the provisions of N.C.G.S. 58-3-100.

Three claims (3.2 percent error ratio) were not processed within 45 days and the Company failed to send a delay notice to the insured. The Company was reminded of the provisions of 11 NCAC 4.0319.

Five claims files (5.3 percent error ratio) did not contain a copy of the claim form. The Company was reminded of the provisions of 11 NCAC 19.0105.

The average service time to process a claim was 17 calendar days. A chart of the service time follows:

Service Days	Number of Files	Percentage of Total
1 - 7	19	20.2
8 - 14	34	36.2
15 - 21	25	26.6
22 - 30	7	7.4
31 - 60	8	8.5
Over 60	1	1.1
Total	**94**	**100.0**

Group Major Medical Claims Denied

A random sample of 50 group major medical/small employer claims denied from a population of 2,585 was reviewed for accuracy, adherence to Company guidelines, and compliance with North Carolina statutes and rules.

Two claims files (4.0 percent error ratio) were considered invalid receipts as the claims were not processed within the examination period. The Company was reminded of the provisions of N.C.G.S. 58-2-131, 58-2-185, and 11 NCAC 19.0106. The review was based on the remaining 48 claims files.

Seven claims (14.6 percent error ratio) were not processed within 30 days and the Company failed to acknowledge receipt of the claim. The Company was deemed to be in apparent violation of the provisions of N.C.G.S. 58-3-100.

Four claims (8.3 percent error ratio) were not processed within 45 days and the Company failed to send a delay letter to the insured. The Company was deemed to be in apparent violation of the provisions of 11 NCAC 4.0319.

Four claims files (8.3 percent error ratio) did not contain a copy of the claim invoice filed by the provider. The Company was deemed to be in apparent violation of the provisions of 11 NCAC 19.0105.

The average service time to process a claim was 20 calendar days. A chart of the service time follows:

Service Days	Number of Files	Percentage of Total
1 - 7	6	12.5
8 - 14	19	39.6
15 - 21	12	25.0
22 - 30	4	8.3
31 - 60	6	12.5
Over 60	1	2.1
Total	**48**	**100.0**

Group Dental Claims Paid

A random sample of 50 claims from a population of 239 was reviewed for accuracy, adherence to Company guidelines, and compliance with North Carolina statutes and rules. No irregularities, adverse trends, or unfair trade practices were perceived in this section of the examination.

The average service time to process a claim was 9 calendar days. A chart of service time follows:

Service Days	Number of Files	Percentage of Total
1 - 7	27	54.0
8 - 14	15	30.0
15 - 21	3	6.0
22 - 30	5	10.0
Total	**50**	**100.0**

Group Dental Claims Denied

All claims from a population of 26 were reviewed for accuracy, adherence to Company guidelines, and compliance with North Carolina statutes and rules.

One claim file (3.9 percent error ratio) was considered an invalid receipt as the file represented a paid claim. The Company was reminded of the provisions of N.C.G.S. 58-2-131, 58-2-185, and 11 NCAC 19.0106. The review was based on the remaining 25 claims.

Four claims files (16.0 percent error ratio) contained an Explanation of Benefits that did not provide the reason the claim was denied. The Company was deemed to be in apparent violation of the provisions of N.C.G.S. 58-63-15.

One claim file (3.9 percent error ratio) was denied in error and excluded from the review. The Company acknowledged the error and mailed a check to the claimant in the amount of $239.19 on November 9, 2001. The review was based on the remaining 24 claims.

The average service time to process a claim was 21 calendar days. A chart of the service time follows:

Service Days	Number of Files	Percentage of Total
1 - 7	1	4.2
8 - 14	3	12.5
15 - 21	8	33.3
22 - 30	10	41.7
31 - 60	2	8.3
Total	**24**	**100.0**

SUMMARY

The Market Conduct examination revealed areas of concern in the following:

1. Concurrent Reviews

    a. The Company was reminded of the provisions of N.C.G.S. 58-2-131, 58-2-185, and 11 NCAC 19.0106 as 4.0 percent of the concurrent reviews were considered invalid receipts.

    b. The Company was deemed to be in apparent violation of the provisions of N.C.G.S. 58-50-61 as 100 percent of the concurrent review files did not contain evidence that the concurrent determinations were communicated to the provider within 3 business days after receiving all necessary information.

2. Retrospective Reviews

    a. The Company was deemed to be in apparent violation of the provisions of N.C.G.S. 58-50-61 as 100 percent of the retrospective reviews did not contain evidence that a noncertification letter was sent to the insured and provider within 5 business days after making the noncertification.

3. Standard Non-Expedited Appeals

    a. The Company was deemed to be in apparent violation of the provisions of N.C.G.S. 58-2-131, 58-2-185, and 11 NCAC 19.0106 as 33.3 percent of the standard non-expedited appeals files were considered invalid receipts.

    b. The Company was deemed to be in apparent violation of the provisions of N.C.G.S. 58-50-61 as 50.0 percent of the standard appeals files did not contain a copy of the acknowledgement letter and the examiner could not determine acknowledgement to the covered person was within 3 working days of the request for appeal.

4. Appointment and Termination of Agents

    a. The Company was reminded of the provisions of 58-2-131, 58-2-185, and 11 NCAC 19.0106 as 4.0 percent of the agent appointment files were considered invalid receipts.

    b. The Company was reminded of the provisions of N.C.G.S. 58-33-40 and 11 NCAC 6A.0412 as 4.2 percent of the agent appointment files did not contain a copy of the Appointment of North Carolina Agent form and the examiner was unable to determine that the Department was notified within 30 days of the agent's appointment date.

c. The Company was deemed to be in apparent violation of the provisions of N.C.G.S. 58-33-30 and 11 NCAC 6A.0412 as 100 percent of the agent appointment files did not contain evidence that a due diligence background check was performed on the agents prior to appointment.

d. The Company was reminded of the provisions of 11 NCAC 19.0102 and 19.0106 as 4.0 percent of the agent termination files were not provided.

e. The Company was deemed to be in apparent violation of the provisions of N.C.G.S. 58-2-131, 58-2-185, and 11 NCAC 19.0106 as 31.3 percent of the agent termination files were considered invalid receipts.

f. The Company was deemed to be in apparent violation of the provisions of N.C.G.S. 58-33-55 as 78.8 percent of the agent termination files did not contain documentation that the agent was notified of termination.

5. Small Employer Group Issued

a. The Company was deemed to be in apparent violation of the provisions of 11 NCAC 19.0102 as 31.2 percent of the small employer group master contract files did not contain the group application or the insureds' applications.

b. The Company was deemed to be in apparent violation of the provisions of N.C.G.S. 58-33-25 and 58-33-40 as 31.2 percent of the small employer group master contract files contained evidence that the agent solicited the business before he was appointed by the Company or was not appointed.

6. Group Major Medical Claims Paid

a. The Company was reminded of the provisions of N.C.G.S. 58-2-131, 58-2-185, and 11 NCAC 19.0106 as 6.0 percent of the claims files were considered invalid receipts.

b. The Company was deemed to be in apparent violation of the provisions of N.C.G.S. 58-3-100 as 9.6 percent of the claims were not processed within 30 days and the Company failed to acknowledge receipt of the claim.

c. The Company was reminded of the provisions of 11 NCAC 4.0319 as 3.2 percent of the claims were not processed within 45 days and the Company failed to send a delay notice to the insured.

d. The Company was reminded of the provisions of 11 NCAC 19.0105 as 5.3 percent of the claims files did not contain a copy of the claim form.

7. Group Major Medical Claims Denied

a. The Company was reminded of the provisions of N.C.G.S. 58-2-131, 58-2-185, and 11 NCAC 19.0106 as 4.0 percent of the claims files were considered invalid receipts.

b. The Company was deemed to be in apparent violation of the provisions of N.C.G.S. 58-3-100 as 14.6 percent of the claims were not processed within 30 days and the Company failed to acknowledge receipt of the claim.

c. The Company was deemed to be in apparent violation of the provisions of 11 NCAC 4.0319 as 8.3 percent of the claims were not processed within 45 days and the Company failed to send a delay letter to the insured.

8. Group Dental Claims Denied

a. The Company was reminded of the provisions of N.C.G.S. 58-2-131, 58-2-185, and 11 NCAC 19.0106 as 3.9 percent of the claims files were considered invalid receipts.

b. The Company was deemed to be in apparent violation of the provisions of N.C.G.S. 58-63-15 as 16.7 percent of the claims contained an Explanation of Benefits that did not provide the reason the claim was denied.

TABLE OF STATUTES AND RULES

Statute/Rule	Title
N.C.G.S. 58-2-131	Examinations to be made; authority, scope, scheduling, and conduct of examinations.
N.C.G.S. 58-2-185	Record of business kept by companies and agents; Commissioner may inspect.
N.C.G.S. 58-3-100	Revocation, suspension and refusal to renew license.
N.C.G.S. 58-3-169	Required coverage for minimum hospital stay following birth.
N.C.G.S. 58-7-15	Kinds of insurance authorized.
N.C.G.S. 58-33-25	General license requirements.
N.C.G.S. 58-33-30	License requirements.
N.C.G.S. 58-33-40	Appointment of agents.
N.C.G.S. 58-33-55	Cancellation reports.
N.C.G.S. 58-50-61	Utilization review.
N.C.G.S. 58-50-62	Insurer grievance procedures.
N.C.G.S. 58-63-15	Unfair methods of competition and unfair or deceptive acts or practices defined.

Statute/Rule	Title
11 NCAC 1.0602	Insurance Companies' Response to Departmental Inquiries.
11 NCAC 4.0319	Claims Practices: Life: Accident and Health Insurance.
11 NCAC 6A.0412	Appointment of Agent: Responsibility of Company.
11 NCAC 12.0307	Filing Approval: Life: Accident and Health Forms.
11 NCAC 12.0431	Life Insurance Advertising: Enforcement Procedures.
11 NCAC 12.0534	Accident and Health Advertising: Certificate of Compliance.
11 NCAC 19.0102	Maintenance of Records.
11 NCAC 19.0103	Complaint Records.
11 NCAC 19.0105	Claim Records.
11 NCAC 19.0106	Records Required for Examination.

CONCLUSION

An examination has been conducted on the market conduct affairs of United HealthCare Insurance Company for the period January 1, 1998 through December 31, 2000 with analyses of certain operations of the Company being conducted through November 9, 2001.

This examination was conducted in accordance with the Department and the National Association of Insurance Commissioners Market Conduct Examination procedures, including analyses of Company operations in the areas of policyholder treatment, utilization review, marketing, underwriting, and claims practices.

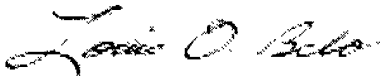
In addition to the undersigned, Sandy Preston, FLMI, CPIW, ALHC, AIRC, and Marion Flemmings, HIAA, North Carolina Market Conduct Examiners, participated in this examination and in the preparation of this report.

I have reviewed this examination report and it meets the provisions for such reports prescribed by this Division and the North Carolina Department of Insurance.

Respectfully submitted,

Ernest L. Nickerson, FLMI, ACS, AIRC
Examiner-In-Charge
Market Examinations Division
State of North Carolina

I have reviewed this examination report and it meets the provisions for such reports prescribed by this Division and the North Carolina Department of Insurance.



Louis O. Belo
Deputy Commissioner
Market Examinations Division
State of North Carolina

02/20/02

OHIO DEPARTMENT OF INSURANCE

REPORT OF

MARKET CONDUCT EXAMINATION

OF

UNITED HEALTHCARE OF OHIO INC.
D/B/A BENEFIT SYSTEMS AND
D/B/A WESTERN OHIO HEALTH CARE CORP.

NAIC #95186

As Of

March 10, 2000

STATE OF OHIO
Department of Insurance
2100 Stella Court Columbus, Ohio 43215-1067
(614) 644-2658 www.state.oh.us/ins

Bob Taft
Governor

J. Lee Covington II
Director

January 12, 2001
Columbus, Ohio

Honorable J. Lee Covington II
Director of Insurance
Ohio Department of Insurance
2100 Stella Court
Columbus, Ohio 43215-1067

Director:

Pursuant to your instructions and in accordance with the powers vested under Title 39 of the Ohio Revised Code, a target market conduct examination was conducted on the Ohio business of:

United HealthCare of Ohio, Inc. d/b/a Benefit Systems and
d/b/a Western Ohio Health Care Corp.
NAIC Company Code 95186

The examination was conducted at the Company's claim processing office, located at:

4500 East Broad Street, Columbus, Ohio, 43213

A report of the examination is enclosed.

Respectfully submitted,

David R. Beck
Chief, Market Conduct Division

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SCOPE OF EXAMINATION

This examination was conducted in accordance with the standards and procedures established by the National Association of Insurance Commissioners (NAIC) and the Ohio Department of Insurance (ODI).

The purpose of the examination was to determine whether the Company adjudicates claims in compliance with the Prompt Pay Law of Ohio, § 3901.38 of the Ohio Revised Code (ORC) and accompanying § 3901-1-60 of the Ohio Administrative Code (OAC).

The Prompt Pay law requires third-party payers to pay completed claims within 24 days or within a different contractual period. Rule 3901-1-60 (E) (1) requires third-party payers to request additional information within 21 days of receipt of a claim that is not "complete."

METHODOLOGY

The Department asked the Company to provide a comprehensive list of health care claims that were closed (paid or denied) between February 10, 2000 and March 10, 2000. The Department pulled a random sample from this population. Claims from capitated providers, self-funded plans, and Medicare, Medicaid and Medicare Supplement claims were excluded.

A series of tests was designed and applied to the sample to determine the Company's level of compliance with Ohio insurance statutes and regulations. The Examiners used the following rules when testing for compliance:

1. The definitions in § 3901.38 (A) ORC were used in constructing and applying all standards and tests. All terms defined in this Section appear in this report in quotes.
2. If the Company's records showed no additional information was needed to "complete" the claim, the date the claim was received was used as the "completed claim" date.

3. If the Company's records showed additional information was needed to "complete" the claim, the date any additional information was received was used as the "completed claim" date.

4. If the Company's records showed additional information was needed from more than one source to "complete" the claim, the date the last piece of additional information was received was used as the "completed claim" date.

5. The date on which the Company issued a check or draft in payment or advised the provider of the claim denial was used as the date the claim was "accepted or rejected" (paid or denied).

6. Standard business database software was used to calculate the number of days between (1) the date a claim was received and the date any additional information was requested; and (2) the date the claim was "complete" and the date it was "accepted or rejected" (paid or denied).

7. All calculations were based upon "calendar days" as defined in § 3901-1-60 (C) (9) OAC.

8. An exception was any instance where (1) the number of days to request any additional information exceeded 21 "calendar days" (2) the number of days to "accept or reject" a "completed claim" exceeded 24 "calendar days" (or any applicable contracted time period) or (3) the Company's claim files contained insufficient documentation to test for compliance.

In each test, the Examiners used the NAIC standard of 7% error ratio to determine whether or not an apparent pattern or practice of non-compliance existed for any given test.

The results of each test are reported separately. The Examiners provided a list of exceptions to the Company. The Company's response to this list was returned to the Examiners with notes as to whether the Company:

- concurred with the findings, and/or
- had additional information for the Examiners to consider, and/or
- proposed remedial action(s) to correct the apparent deficiency.

Where appropriate, the Company's responses and the Examiners' recommendations are included.

TIMELY INVESTIGATION OF HEALTH CARE CLAIMS

Standard: Should a third-party payer determine that additional information is needed to enable it to accept or reject the claim, that information must be requested within twenty-one (21) days of receiving a claim.

Test: Did the Company's claim investigation practices conform to § 3901-1-60 (E) (1) OAC ?

Findings:

Population	Sample	Yes	No	Standard	Findings
454,396	100	100	0	93%	100%

The standard of compliance is 93%. The Company's claim investigation practices appear to meet acceptable standards.

TIMELY SETTLEMENT OF HEALTH CARE CLAIMS

Standard: A third-party payer shall either deny the claim or tender payment of any amount not in dispute within twenty-four (24) days (or any applicable contracted time period) of receiving a "completed claim."

Test: Did the Company's claim settlement practices conform to § 3901.38 (B) (1) of the ORC and § 3901-1-60 (E) (2) OAC?

Findings:

Population	Sample	Yes	No	Standard	Findings
454,396	100	99	1	93%	99%

The standard of compliance is 93%. The Company's claim settlement practices met the minimum standard.

SUMMARY

The Company's performance in the targeted compliance areas appears to meet acceptable standards.

Robert B. Baker, CIE
Examiner in Charge

January 12, 2001
Date

OHIO DEPARTMENT OF INSURANCE

REPORT OF

MARKET CONDUCT EXAMINATION

OF

UNITED HEALTHCARE INSURANCE COMPANY
NAIC # 79413

As Of

March 10, 2000

State Of Ohio
Department of Insurance
2100 Stella Court Columbus, Ohio 43215-1067
(614) 644-2658 www.ohioinsurance.gov

Bob Taft
Governor

J. Lee Covington II
Director

January 12, 2001
Columbus, Ohio

Honorable J. Lee Covington II
Director of Insurance
Ohio Department of Insurance
2100 Stella Court
Columbus, Ohio 43215-1067

Director:

Pursuant to your instructions and in accordance with the powers vested under Title 39 of the Ohio Revised Code, a target market conduct examination was conducted on the Ohio business of:

United HealthCare Insurance Company
NAIC Company Code 79413

The examination was conducted at the Company's claim processing office, located at:

4500 East Broad Street, Columbus, Ohio, 43213

A report of the examination is enclosed.

Respectfully submitted,

David R. Beck
Chief, Market Conduct Division

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SCOPE OF EXAMINATION

This examination was conducted in accordance with the standards and procedures established by the National Association of Insurance Commissioners (NAIC) and the Ohio Department of Insurance (ODI).

The purpose of the examination was to determine whether the Company adjudicates claims in compliance with the Prompt Pay Law of Ohio, § 3901.38 of the Ohio Revised Code (ORC) and accompanying § 3901-1-60 of the Ohio Administrative Code (OAC).

The Prompt Pay law requires third-party payers to pay completed claims within 24 days or within a different contractual period. Rule 3901-1-60 (E) (1) requires third-party payers to request additional information within 21 days of receipt of a claim that is not "complete."

METHODOLOGY

The Department asked the Company to provide a comprehensive list of health care claims that were closed (paid or denied) between February 10, 2000 and March 10, 2000. The Department pulled a random sample from this population. Claims from capitated providers, self-funded plans, and Medicare, Medicaid and Medicare Supplement claims were excluded.

A series of tests was designed and applied to the sample to determine the Company's level of compliance with Ohio insurance statutes and regulations. The Examiners used the following rules when testing for compliance:

1. The definitions in § 3901.38 (A) ORC were used in constructing and applying all standards and tests. All terms defined in this Section appear in this report in quotes.
2. If the Company's records showed no additional information was needed to "complete" the claim, the date the claim was received was used as the "completed claim" date.

3. If the Company's records showed additional information was needed to "complete" the claim, the date any additional information was received was used as the "completed claim" date.

4. If the Company's records showed additional information was needed from more than one source to "complete" the claim, the date the last piece of additional information was received was used as the "completed claim" date.

5. The date on which the Company issued a check or draft in payment or advised the provider of the claim denial was used as the date the claim was "accepted or rejected" (paid or denied).

6. Standard business database software was used to calculate the number of days between (1) the date a claim was received and the date any additional information was requested; and (2) the date the claim was "complete" and the date it was "accepted or rejected" (paid or denied).

7. All calculations were based upon "calendar days" as defined in § 3901-1-60 (C) (9) OAC.

8. An exception was any instance where (1) the number of days to request any additional information exceeded 21 "calendar days" (2) the number of days to "accept or reject" a "completed claim" exceeded 24 "calendar days" (or any applicable contracted time period) or (3) the Company's claim files contained insufficient documentation to test for compliance.

In each test, the Examiners used the NAIC standard of 7% error ratio to determine whether or not an apparent pattern or practice of non-compliance existed for any given test.

The results of each test are reported separately. The Examiners provided a list of exceptions to the Company. The Company's response to this list was returned to the Examiners with notes as to whether the Company:

- concurred with the findings, and/or
- had additional information for the Examiners to consider, and/or
- proposed remedial action(s) to correct the apparent deficiency.

Where appropriate, the Company's responses and the Examiners' recommendations are included.

TIMELY INVESTIGATION OF HEALTH CARE CLAIMS

Standard: Should a third-party payer determine that additional information is needed to enable it to accept or reject the claim, that information must be requested within twenty-one (21) days of receiving a claim.

Test: Did the Company's claim investigation practices conform to § 3901-1-60 (E) (1) OAC ?

Findings:

Population	Sample	Yes	No	Standard	Findings
88,707	100	100	0	93%	100%

The standard of compliance is 93%. The Company's claim investigation practices appear to meet acceptable standards.

TIMELY SETTLEMENT OF HEALTH CARE CLAIMS

Standard: A third-party payer shall either deny the claim or tender payment of any amount not in dispute within twenty-four (24) days (or any applicable contracted time period) of receiving a "completed claim."

Test: Did the Company's claim settlement practices conform to § 3901.38 (B) (1) of the ORC and § 3901-1-60 (E) (2) OAC?

Findings:

Population	Sample	Yes	No	Standard	Findings
88,707	100	100	0	93%	100%

The standard of compliance is 93%. The Company's claim settlement practices met the minimum standard.

SUMMARY

The Company's performance in the targeted compliance areas appears to meet acceptable standards.

Robert Baker
Robert B. Baker, CIE
Examiner in Charge

January 12, 2001
Date

OHIO DEPARTMENT OF INSURANCE

REPORT OF

MARKET CONDUCT EXAMINATION

OF

UNITED HEALTHCARE INSURANCE COMPANY OF OHIO
NAIC #73518

As Of

March 10, 2000

STATE OF OHIO
Department of Insurance
2100 Stella Court Columbus, Ohio 43215-1067
(614) 644-2658 www.state.oh.us/ins

Bob Taft
Governor

J. Lee Covington II
Director

January 12, 2001
Columbus, Ohio

Honorable J. Lee Covington II
Director of Insurance
Ohio Department of Insurance
2100 Stella Court
Columbus, Ohio 43215-1067

Director:

Pursuant to your instructions and in accordance with the powers vested under Title 39 of the Ohio Revised Code, a target market conduct examination was conducted on the Ohio business of:

United HealthCare Insurance Company of Ohio
NAIC Company Code 73518

The examination was conducted at the Company's claim processing office, located at:

4500 East Broad Street, Columbus, Ohio, 43213

A report of the examination is enclosed.

Respectfully submitted,

David R. Beck
Chief, Market Conduct Division

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SCOPE OF EXAMINATION

This examination was conducted in accordance with the standards and procedures established by the National Association of Insurance Commissioners (NAIC) and the Ohio Department of Insurance (ODI).

The purpose of the examination was to determine whether the Company adjudicates claims in compliance with the Prompt Pay Law of Ohio, § 3901.38 of the Ohio Revised Code (ORC) and accompanying § 3901-1-60 of the Ohio Administrative Code (OAC).

The Prompt Pay law requires third-party payers to pay completed claims within 24 days or within a different contractual period. Rule 3901-1-60 (E) (1) requires third-party payers to request additional information within 21 days of receipt of a claim that is not "complete."

METHODOLOGY

The Department asked the Company to provide a comprehensive list of health care claims that were closed (paid or denied) between February 10, 2000 and March 10, 2000. The Department pulled a random sample from this population. Claims from capitated providers, self-funded plans, and Medicare, Medicaid and Medicare Supplement claims were excluded.

A series of tests was designed and applied to the sample to determine the Company's level of compliance with Ohio insurance statutes and regulations. The Examiners used the following rules when testing for compliance:

1. The definitions in § 3901.38 (A) ORC were used in constructing and applying all standards and tests. All terms defined in this Section appear in this report in quotes.
2. If the Company's records showed no additional information was needed to "complete" the claim, the date the claim was received was used as the "completed claim" date.

3. If the Company's records showed additional information was needed to "complete" the claim, the date any additional information was received was used as the "completed claim" date.

4. If the Company's records showed additional information was needed from more than one source to "complete" the claim, the date the last piece of additional information was received was used as the "completed claim" date.

5. The date on which the Company issued a check or draft in payment or advised the provider of the claim denial was used as the date the claim was "accepted or rejected" (paid or denied).

6. Standard business database software was used to calculate the number of days between (1) the date a claim was received and the date any additional information was requested; and (2) the date the claim was "complete" and the date it was "accepted or rejected" (paid or denied).

7. All calculations were based upon "calendar days" as defined in § 3901-1-60 (C) (9) OAC.

8. An exception was any instance where (1) the number of days to request any additional information exceeded 21 "calendar days" (2) the number of days to "accept or reject" a "completed claim" exceeded 24 "calendar days" (or any applicable contracted time period) or (3) the Company's claim files contained insufficient documentation to test for compliance.

In each test, the Examiners used the NAIC standard of 7% error ratio to determine whether or not an apparent pattern or practice of non-compliance existed for any given test.

The results of each test are reported separately. The Examiners provided a list of exceptions to the Company. The Company's response to this list was returned to the Examiners with notes as to whether the Company:

- concurred with the findings, and/or
- had additional information for the Examiners to consider, and/or
- proposed remedial action(s) to correct the apparent deficiency.

Where appropriate, the Company's responses and the Examiners' recommendations are included.

TIMELY INVESTIGATION OF HEALTH CARE CLAIMS

Standard: Should a third-party payer determine that additional information is needed to enable it to accept or reject the claim, that information must be requested within twenty-one (21) days of receiving a claim.

Test: Did the Company's claim investigation practices conform to § 3901-1-60 (E) (1) OAC ?

Findings:

Population	Sample	Yes	No	Standard	Findings
34,926	100	98	2	93%	98%

The standard of compliance is 93%. The Company's claim investigation practices appear to meet acceptable standards.

TIMELY SETTLEMENT OF HEALTH CARE CLAIMS

Standard: A third-party payer shall either deny the claim or tender payment of any amount not in dispute within twenty-four (24) days (or any applicable contracted time period) of receiving a "completed claim."

Test: Did the Company's claim settlement practices conform to § 3901.38 (B) (1) of the ORC and § 3901-1-60 (E) (2) OAC?

Findings:

Population	Sample	Yes	No	Standard	Findings
34,926	100	84	16	93%	84%

The standard of compliance is 93%. The Company's claim settlement practices do not meet the minimum standard.

Examiners' Comments

The Company failed to pay or deny "completed claims" within the time limits provided by the state statute.

Company's Response:

Three of UnitedHealth Group's family of companies, UnitedHealthcare Insurance Company of Ohio (UHIC of Ohio), UnitedHealthcare of Ohio, Inc. (UHCO) and UnitedHealthcare Insurance Company (UHIC), were part of the Ohio Department of Insurance's prompt pay audit.

The Department examined 100 claims from each company. As detailed in the audit report, UnitedHealthcare Insurance Company of Ohio scored 84% (unsatisfactory). We believe it is significant in putting our over-all performance in perspective to report as well that UnitedHealthcare of Ohio, Inc received a 99% score and UnitedHealthcare Insurance Company received a perfect 100% score in that same audit.

If the 300 claims reviewed as part of the audit are viewed in aggregate, the overall performance of the three UnitedHealth Group companies was better than 94% (93% is "satisfactory"). Even the 94%, calculated by averaging the results of the three companies, understates our over-all performance. UnitedHealthcare Insurance Company of Ohio is the smallest segment of our Ohio market.

We recognize that each of our three companies is separately licensed and subject to regulation and do not challenge the Department's right to sanction UnitedHealthcare Insurance Company of Ohio as it has. In all of our companies, we take very seriously our obligation to comply with all applicable laws and regulations. Moreover, we value our relationships with Ohio's health care providers. We have already implemented

measures to improve UnitedHealthcare Insurance Company of Ohio's timely claims payment performance.

We are proud of our over-all level of compliance with the Ohio prompt pay law as confirmed by the audit.

Recommendations:

1. The Company shall design and implement procedures to assure that completed claims are paid or denied within 24 days of the date of receipt.
2. The Company shall provide the Examiners with copies of these procedures and all bulletins issued to claim personnel.
3. The Company shall develop and implement audit procedures that monitor compliance with its procedures.
4. The Company shall provide the Examiners with copies of the results of these audits six months following the date of any consent order, or the date of this report, whichever is later.

SUMMARY

The Company's performance in the targeted compliance areas appears to fall below acceptable standards.

Robert B. Baker, CIE
Examiner in Charge

January 12, 2001
Date

STATE OF OHIO
DEPARTMENT OF INSURANCE

IN THE MATTER OF:	:	
UNITED HEALTHCARE	:	CONSENT ORDER
INSURANCE COMPANY OF OHIO	:	
MARKET CONDUCT EXAMINATION	:	

The Superintendent of the Ohio Department of Insurance (hereinafter the "Superintendent") is responsible for administering Ohio insurance laws pursuant to Ohio Revised Code (hereinafter "ORC") Section 3901.011. United HealthCare Insurance Company of Ohio (hereinafter the "Company") is authorized to engage in the business of insurance in the State of Ohio and as such is under the jurisdiction of the Superintendent. The Superintendent conducted an examination of the Company's claims handling practices to ensure compliance with ORC Section 3901.38 and Ohio Administrative Code (hereinafter "OAC") Section 3901-1-60. The Superintendent alleges that at the time of the examination the Company was not in statutory compliance.

IT IS HEREBY AGREED AND CONSENTED TO BY THE PARTIES THAT:

1) The examination covered health care claims paid or denied from February 10, 2000 to March 10, 2000. The Superintendent alleges that during that period the Company failed to comply with ORC Section 3901.38.

2) The Company hereby agrees to modify its health claims handling practices to ensure compliance with ORC Section 3901.38. This modification shall be outlined in a Corrective Action Plan that is subject to the Superintendent's approval.

3) The Corrective Action Plan shall detail the Company's changes to procedures and/or internal policies to ensure compliance with ORC Section 3901.38. The Corrective Action Plan will include training and/or education to Providers{as defined in ORC Section 3901.38 (A)(6)} in what information is necessary for a completed claim.

#3603

4) The Corrective Action Plan shall be submitted to the Superintendent for approval within thirty (30) days of this order.

5) The Superintendent reserves the right to conduct an examination to ensure the Company's compliance with ORC Section 3901.38. This examination will commence no earlier than six (6) months from the date of this agreement. The Company agrees to implement reasonable changes to the Corrective Action Plan as suggested by the Superintendent.

6) The Company shall pay an administrative fine in the amount of $85,000 by check or money order made payable to the Ohio Department of Insurance on or before February 28, 2001.

7) This shall be in lieu of any other administrative penalty that may be imposed by the Superintendent.

8) The Company will also pay $1,027.12 in administrative costs incurred by the Department of Insurance to perform the Market Conduct examination by check or money order on or before February 28, 2001.

9) The Company hereby waives its rights to a public hearing and appeal of this order pursuant to ORC Chapter 119.

10) This is a public document and a copy shall be entered into the Journal of the Ohio Department of Insurance.

Name: _____
Ronald B. Colby
President
United HealthCare Insurance Company of Ohio

Date: April 12, 2001 _____
J. Lee Covington II
Superintendent of Insurance

OHIO DEPARTMENT OF INSURANCE

A

TARGETED

MARKET CONDUCT EXAMINATION

OF

UNITED HEALTHCARE INSURANCE COMPANY OF OHIO

NAIC #73518

As Of

December 31, 2001

OHIO Department of INSURANCE

Bob Taft, Governor
Ann Womer Benjamin, Director
2100 Stella Court, Columbus, OH 43215-1067
(614) 644-2658 www.ohioinsurance.gov

Honorable Ann Womer Benjamin
Director
Ohio Department of Insurance
2100 Stella Court
Columbus, Ohio 43215-1067

Director:

Pursuant to your instructions and in accordance with the powers vested under Title 39 of the Ohio Revised Code, a target market conduct examination was conducted on the Ohio business of:

United HealthCare Insurance Company of Ohio
NAIC Company Code 73518

The examination was conducted at the Company's Uniprise Regional Claims Processing Center located at:

4316 Rice Lake Road, Duluth, Minnesota 55811

A report of the examination is enclosed.

Respectfully submitted,

David R. Beck
Chief, Market Conduct Division

Date: April 5 2004

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SCOPE OF EXAMINATION

This examination was conducted in accordance with the standards and procedures established by the National Association of Insurance Commissioners (NAIC) and the Ohio Department of Insurance (the Department).

The purpose of the examination was to determine whether United HealthCare Insurance Company of Ohio, (the Company) had implemented modifications to the Company's health claim practices as ordered April 12, 2001, by the Superintendent.

METHODOLOGY

The Department asked the Company to provide a comprehensive list of health care claims that were closed (paid or denied) between October 1, 2001 and December 31, 2001. The Department pulled a random sample of 100 claims for each month from this population. Claims from capitated providers, self-funded plans, workers compensation, and Medicare, Medicare+Choice, Medicare Supplement and Medicaid claims were excluded.

A series of tests were designed and applied to the sample to determine the Company's level of compliance with Ohio insurance statutes and regulations. The Examiners used the following rules when testing for compliance:

1. The definitions in § 3901.38 (A) ORC were used in constructing and applying all standards and tests. All terms defined in this Section appear in this report in quotes.
2. If the Company's records showed no additional information was needed to "complete" the claim, the date the claim was received was used as the "completed claim" date.

3. If the Company's records showed additional information was needed, and when it was received the claim was not a "completed claim," the date any additional information was received was used as the "completed claim" date.
4. If the Company's records showed additional information was needed from more than one source, the date the last piece of additional information was received was used as the "completed claim" date.
5. The date on which the Company issued a check or draft in payment or advised the provider of the claim denial was used as the date the Company "accepted or rejected" (paid or denied) the claim.
6. Standard business database software was used to calculate the number of days between (1) the date a claim was received and the date any additional information was requested; and (2) the date the claim was complete and the date it was "accepted or rejected" (paid or denied).
7. All calculations were based upon "days" as defined in § 3901-1-60 (C) (9) OAC.
8. An exception was any instance where (1) the number of days to request any additional information exceeded 21 "days" (2) the number of days to "accept or reject" a "completed claim" exceeded 24 "days" (or any applicable contracted time period) or (3) the Company's claim files contained insufficient documentation to test for compliance.

In each test, the Examiners used the NAIC standard of 7% error ratio to determine whether an apparent pattern or practice of non-compliance existed for any given test.

The results of each test are reported separately. The Examiners provided a list of exceptions to the Company. The Company's response to this list was returned to the Examiners with notes as to whether the Company:

- concurred with the findings, and/or

- had additional information for the Examiners to consider, and/or
- proposed remedial action(s) to correct the apparent deficiency.

TIMELY INVESTIGATION OF HEALTH CARE CLAIMS

Standard: Should a third-party payer determine that additional information is needed to enable it to accept or reject the claim, that information must be requested within twenty-one (21) days of receiving a claim.

Test: Did the Company's claim investigation practices conform to § 3901-1-60 (E) (1) OAC ?

Findings:

Population	Sample	Yes	No	Standard	Findings
92,609	300	300	0	93%	100%

The standard of compliance is 93%. The Company's claim investigation practices appear to meet acceptable standards.

TIMELY SETTLEMENT OF HEALTH CARE CLAIMS

Standard: A third-party payer shall either deny the claim or tender payment of any amount not in dispute within twenty-four (24) days (or any applicable contracted time period) of receiving a "completed claim."

Test: Did the Company's claim settlement practices conform to § 3901.38 (B) (1) of the ORC and § 3901-1-60 (E) (2) OAC?

Findings:

Population	Sample	Yes	No	Standard	Findings
92,609	300	275	25	93%	91%

The standard of compliance is 93%. The Company's claim settlement practices do not appear to meet acceptable standards.

CLAIM FILE DOCUMENTATION

Standard: Every third party payer shall maintain claim files with sufficiently detailed documentation to permit reconstruction of the payer's claim settlement activities.

Test: Do the Company's claim records conform to §3901-1-60 (H) (2) OAC?

Findings:

Population	Sample	Yes	No	Standard	Findings
92,609	300	298	2	93%	99%

The standard of compliance is 93%. The Company's claim file documentation practices appear to meet acceptable standards.

Examiners' Comments: The Examiners took exception in two instances where the Company's claim records reflected a "paid" date prior to the "posted" date of the claim. When a claim is "posted" within the Company's claims payment system, the adjudication process has been completed and the claim is released for payment or denial. The "paid date", as defined by the Company, is the date the check physically leaves the Company via U.S. Mail and sent to the provider. Although the Company found this illogical progression of dates to be somewhat suspect as well, a clear explanation was not provided. The Company did surmise that their "payment cycles" (process of issuing batch payments and printing checks) periodically last for more than 24 hours, and that the illogical date progression *may* have resulted from this lengthy process.

SUMMARY

The Company's performance in the targeted compliance areas does not appear to meet acceptable standards.

Rodney E Beetch — 4-5-04

Rodney Beetch
Examiner in Charge

Date

UnitedHealthcare
A UnitedHealth Group Company

UnitedHealthcare
9200 Worthington Road Westerville, Ohio 43082
Tel 614 410 7000 Fax 614 410 1011

November 22, 2002

Mr. David R. Beck
Chief, Market Conduct Division
Ohio Department of Insurance
2100 Stella Court
Columbus, Ohio 43215-1067

RE: UnitedHealthcare Insurance Company of Ohio
NAIC Company Code 73518
Target Market Conduct Examination Report

Dear Mr. Beck:

Thank you for giving us the opportunity to comment on the results of the market conduct examination. It is UnitedHealthcare's policy to pay claims within the timeframe required by state law. As we discussed with you, we agree that we did not meet the claims payment standard for some of the claims in the sample.

Although we recognize the new 30-day standard does not apply to the time period reviewed, the results of the sample would have exceeded 94%, as there were 8 of the 25 exceptions that were paid in less than 30 days, but greater than 24 days. Under current requirements, we would have met the acceptable standard. We will continue to evaluate our current policies and procedures to ensure that our claim settlement practices allow us to pay claims within the timeframe allowed by Ohio law.

Again, thank you for giving us the opportunity to respond.

Sincerely,

Brett Baby
President
UnitedHealthcare Insurance Company of Ohio

OHIO DEPARTMENT OF INSURANCE

REPORT OF

MARKET CONDUCT EXAMINATION OF

UNITED HEALTHCARE INSURANCE COMPANY OF OHIO
NAIC #73518

AND

UNITED HEALTHCARE OF OHIO INC.
NAIC #95186

As Of

March 31, 2002

OHIO Department of INSURANCE

Bob Taft, Governor
Ann Womer Benjamin, Director
2100 Stella Court, Columbus, OH 43215-1067
(614) 644-2658 www.ohioinsurance.gov

July 19, 2004
Columbus, Ohio

Honorable Ann Womer Benjamin
Director of Insurance
Ohio Department of Insurance
2100 Stella Court
Columbus, Ohio 43215-1067

Director:

Pursuant to your instructions and in accordance with the powers vested under Title 39 of the Ohio Revised Code, a target market conduct examination was conducted on the Ohio business of:

United HealthCare Insurance Company of Ohio
NAIC Company Code 73518

United Healthcare of Ohio Inc.
NAIC Company Code 95186

The examination was conducted at the Company's Uniprise Regional Claims Processing Center, located at:

4316 Rice Lake Road, Duluth, Minnesota 55811

A report of the examination is enclosed.

Respectfully submitted,

David R. Beck
Chief, Market Conduct Division

TABLE OF CONTENTS

SCOPE OF EXAMINATION

This examination was conducted in accordance with the standards and procedures established by the National Association of Insurance Commissioners (NAIC) and the Ohio Department of Insurance (the Department).

The purpose of the examination was to determine whether United HealthCare Insurance Company of Ohio and United Healthcare of Ohio Inc. (the Company), are processing claim denials in accordance with policy provisions and are not in violation of any unfair trade practices as provided in section 3901-1-07 of the Ohio Administrative Code.

METHODOLOGY

The Department asked the Company to provide a comprehensive list of health care claims that were closed without payment, i.e. denied, between October 1, 2001 and March 31, 2002. Due to the claim population size for United Healthcare of Ohio Inc., the population was separated by the Company's various processing centers and by the month the claim was closed. The Department pulled a random sample of 100 claims for each month from each processing center. The United HealthCare Insurance Company of Ohio had a much smaller population, therefore, a single random sample of 100 claims for each month was selected. Additional samples from each company were also pulled based on claim specific identifiers. Claims from capitated providers, self-funded plans, workers compensation, and Medicare, Medicare+Choice, Medicare Supplement and Medicaid claims were excluded.

A series of tests was designed and applied to the samples to determine the Company's level of compliance with Ohio insurance statutes and regulations. Specifically, the samples were reviewed for compliance with Ohio Administrative Code 3901-1-07, Ohio's unfair trade practices regulation. These tests are described and the results are noted in this report. In any instance where the Examiners could not find sufficient documentation for the examination test, the claim file documentation was considered incomplete.

In each test, the Examiners used the NAIC standard of 7% error ratio to determine whether an apparent pattern or practice of non-compliance existed for any given test.

The results of each test are reported separately. The Examiners provided a list of exceptions to the Company. The Company's response to this list was returned to the Examiners with notes as to whether the Company:

- concurred with the findings, and/or
- had additional information for the Examiners to consider, and/or
- proposed remedial action(s) to correct the apparent deficiency.

UNITED HEALTHCARE INSURANCE COMPANY OF OHIO

Standard: Denied and closed-without payment claims are handled in accordance with policy provisions and state law.

Test: Did the Company's claim denial practices conform to Section 3901-1-07 (C) (1-16) of the Ohio Administrative Code and were the claims appropriately denied according to policy provisions?

Findings: During the period, the Company denied 40,923 claims. The population was divided as follows:

Sample File Name	Population	Sample	Yes	No	Standard	Findings
f701s	4,900	50	46	4	93%	100%
f702s	4,943	50	49	1	93%	98%
f703s	6,616	100	95	5	93%	95%
f710s	5,153	100	99	1	93%	99%
f711s	5,236	100	99	1	93%	99%
f712s	6,127	100	100	0	93%	100%
a7010s	25	25	25	0	93%	100%
a7072s	59	59	57	2	93%	97%
a7087s	298	50	50	0	93%	100%
a7098s	1,850	50	48	2	93%	96%
a7284s	371	50	50	0	93%	100%
a7289s	363	50	50	0	93%	100%

a7292s	313	50	50	0	93%	100%
a7380s	327	50	50	0	93%	100%
a7381s	139	50	48	2	93%	96%
a7391s	42	42	42	0	93%	100%
a7459s	27	27	27	0	93%	100%
a7miss	4,134	50	50	0	93%	100%

The standard of compliance is 93%. The Company's claim denial practices meet or exceed the minimum standard in all 18 samples tested.

UNITED HEALTHCARE OF OHIO INC.

Standard: Denied and closed-without payment claims are handled in accordance with policy provisions and state law.

Test: Did the Company's claim denial practices conform to Section 3901-1-07 (C) (1-16) of the Ohio Administrative Code and were the claims appropriately denied according to policy provisions?

Findings: During the period, the Company denied 643,831 claims. The population was divided as follows:

Sample File Name	Population	Sample	Yes	No	Standard	Findings
cin901s	10,877	100	98	2	93%	98%
cin902s	11,674	100	97	3	93%	97%
cin903s	14,597	100	94	6	93%	94%
cin910s	13,869	100	97	3	93%	97%
cin911s	11,246	100	95	5	93%	95%
cin912s	13,622	100	98	2	93%	98%
cle901s	11,689	100	95	5	93%	95%
cle902s	13,449	100	95	5	93%	95%

cle903s	18,032	100	93	7	93%	93%
cle910s	14,933	100	96	4	93%	96%
cle911s	12,633	100	97	3	93%	97%
cle912s	15,866	100	98	2	93%	98%
col901s	22,703	100	100	0	93%	100%
col902s	25,272	100	99	1	93%	99%
col903s	33,842	100	96	4	93%	96%
col910s	28,501	100	97	3	93%	97%
col911s	25,406	100	99	1	93%	99%
col912s	32,211	100	98	2	93%	98%
day901s	20,782	100	97	3	93%	97%
day902s	24,806	100	99	1	93%	99%
day903s	30,580	100	93	7	93%	93%
day910s	28,886	100	99	1	93%	99%
day911s	22,457	100	98	2	93%	98%
day912s	27,506	100	93	7	93%	93%
a9010s	118	50	50	0	93%	100%
a9072s	72	50	49	1	93%	98%
a9087s	4,063	50	50	0	93%	100%
a9098s	990	50	50	0	93%	100%
a9284s	10,653	100	100	0	93%	100%
a9289s	7,262	100	98	2	93%	98%
a9292s	24,143	100	97	3	93%	97%
a9294s	866	50	50	0	93%	100%
a9349s	53	53	53	0	93%	100%
a9380s	19,607	100	100	0	93%	100%
a9381s	3,179	50	50	0	93%	100%
a9391s	559	50	50	0	93%	100%
a9459s	206	50	45	5	93%	90%
a9miss	85,647	100	99	1	93%	99%
net901s	10,254	100	95	5	93%	95%
net902s	11,699	100	99	1	93%	99%
net903s	13,409	100	97	3	93%	97%
net910s	8,076	100	96	4	93%	96%

net911s	7,466	100	92	8	93%	92%
net912s	7,243	100	94	6	93%	94%
net937s	37	37	37	0	93%	100%

The standard of compliance is 93%. The Company's claim denial practices meet or exceed the minimum standard in 43 of the 45 samples tested.

SUMMARY

The Company's performance in the targeted compliance areas met or exceeded the minimum standard in 61 of the 63 of the samples tested.

Throughout the course of the examinations of both United HealthCare Insurance Company of Ohio and United Healthcare of Ohio Inc., the Examiners found several instances where claims were inappropriately denied. Upon review with the Company, the Company agreed the claims were inappropriately denied and agreed to reprocess and pay the claims in question. At the conclusion of the examination, the Company agreed to supply the Examiners with documentation supporting the reprocessing and payment of the claims in question. The Examiners requested that the list be signed from a member of senior management.

The Company has assured the Examiners that the list of reprocessed and paid claims will be provided. The Company has been asked on several occasions, both on-site and by telephone after the Examiners returned, to supply the list of reprocessed and paid claims.

Recommendation:

Complete documentation must be provided as requested by the Department to document the reprocessing and payment of previously denied claims. See Section 3901-1-07 (3) of the Ohio Administrative Code. As of today's date, the Company has supplied the requested documentation.

Additionally, the Examiners note that it is the Company's claims handling practice to deny all claims received that are not complete or are missing information to adjudicate a claim. Each time additional documentation is received by the Company, a new claim number is established. This practice can lead to multiple submissions from providers for the same claim, all with different claim numbers. Such denials appear to be in violation of Section 3901-1-60 (E)(1) (in effect until October 28, 2002).

To further complicate the situation, the 'Provider Remittance Advice' includes denial codes, but it lacks beneficial information that would enable a provider to successfully resubmit the claim. The Company's claims handling practice creates confusion, causes unnecessary re-submissions from providers and leads to an unnecessary number of denials from the Company.

Originally, the Department had concerns with the denying of claims that were incomplete or missing information required for adjudication. These concerns were discussed with the Company. Given that Ohio's prompt pay law was amended effective on July 24, 2002, the Department did not pursue this issue in this exam.

The Department will be conducting an investigation to determine what processing or adjudication changes have been implemented to ensure that the Company's claims adjudication process is in full compliance with Ohio Revised Code 3901.38.1 et seq. In addition to other matters, the Department will be reviewing whether the Company properly requests additional information that may be required.

This concludes the report of the Market Conduct Examination of United HealthCare Insurance Company of Ohio and United Healthcare of Ohio Inc.

Brett C. Helf
Examiner in Charge

7/19/04
Date

Uniprise®
A UnitedHealth Group Company
People. Technology. Solutions.

MEMORANDUM

Date: Friday, April 09, 2004

To: Linda Cullen

From: Joan Goossens

Re: OHO DOI audit from 2002

The OHO DOI audit of 2002 identified 2708 hospital claims and 71 physician claims were inappropriately denied and required adjustment.

We verified that all 2708 hospital claims and all 71 physician claims were adjusted in 2002.

Please let me know if you need anything else.

Sincerely,

Joan Goossens 4/9/04

Joan Goossens
Regional Quality Manger
Duluth, MN
218-279-6502

Market Conduct Examination of
United HealthCare of Wisconsin, Inc.
Conducted March 24 – June 24, 2003

Below are the recommendations noted in the summary of Comments and Recommendations, followed by the Company's response.

Claims

1. **It is recommended that the Company develop a written procedure specific to Wisconsin chiropractic claims for handling of claim and coverage issues related to limiting or terminating chiropractic services. § 632.875 Wis. Stat.**

   Company Response:

   The Company agrees with the recommendation and will develop a written procedure specific to Wisconsin to address handling of claim and coverage issues related to limiting or terminating chiropractic services.

2. **It is recommended that the Company modify the form letters it sends to treating chiropractors and patients regarding Wisconsin chiropractic claims to contain all of the information required by § 632.875 (2)(a)-(h) Wis. Stat.**

   Company Response:

   The Company agrees with the recommendation and will modify the form letters for treating chiropractors and patients to contain information required by Wisconsin law.

3. **It is recommended that the Company correct the identified system problem so that ANSI codes are printed on generated EOB forms for Wisconsin certificate holders as required by § Ins. 3.651(4)(a)5f Wis. Adm. Code.**

   Company Response:

   The Company agrees with the recommendation and has begun printing claims adjustment reason (ANSI) codes on the Explanation of Benefits. System issues were corrected by December 6, 2003.

4. **It is recommended that the Company develop written procedures and corresponding letters to ensure that requests from Wisconsin certificate holders for information related to the specific methodology used by the Company in adjudicating claims are answered as required by § Ins. 3.60(6) Wis. Adm. Code.**

   Company Response:

   The Company agrees with the recommendation and has updated the response letters sent to the customer to explain the methodology used for out of network claims adjudication. The Company will also revise the associated procedures.

Policyholder Services and Complaints

5. **It is recommended that the Company revise the manner in which it maintains a record of complaints so that it can retrieve complaint information related to Wisconsin insureds for review by OCI in order to comply with § Ins 18.06(1) Wis. Adm. Code.**

Company Response:

The Company agrees with the recommendation and has enhanced data retrieval functionality so that we can provide reports of complaints by state.

6. **It is recommended that the Company revise its complaint procedures involving the handling of OCI complaints to reflect its stated practice of contacting the complainant within 10 days of receiving the complaint per OCI referral instructions in order to comply with §. 601.42 Wis. Stat.**

Company Response:

The Company agrees with the recommendation. The Company has significantly revised the complaint and appeal processes since the conclusion of the audit work in July 2003. We believe the enhancements to processes have improved the response timeframe for OCI complaints.

Grievance and Independent Review

7. **It is recommended that the Company revise the definition of complaint in its written procedures to comply with the definition of § Ins 18.01(2), Wis. Adm. Code and to handle as grievances all written communications that meet the definition of a grievance in § Ins 18.01, (4) Wis. Adm. Code.**

Company Response:

The Company agrees with the recommendation and revised the definition of a complaint to reflect Wisconsin requirements.

8. **It is recommended that the Company revise its definition of an appeal (grievance) to comply with the requirements of § Ins 18.01(4) Wis. Adm. Code.**

Company Response:

The Company agrees with the recommendation and has revised the definition of an appeal (grievance) to reflect Wisconsin requirements.

9. **It is recommended that the Company revise its procedures to handle as grievances written expressions of dissatisfaction involving quality of care issues as required by § Ins 18.01(4) and §. Ins 18.03 Wis. Adm. Code.**

Company Response:

The Company agrees with the recommendation and will revise its procedures to handle as a grievance all written expressions of dissatisfaction involving quality of care issues.

10. **It is recommended that the Company revise its appeal/grievance procedures to schedule all unfavorable 1st Level Appeal grievances for hearing by the grievance committee rather than requiring the grievant to request a 2nd Level formal hearing as required by § Ins 18.03 Wis. Adm. Code.**

Company Response:

The Company agrees with the recommendation and will implement a procedure to schedule all unfavorable 1st Level grievances for hearing by the grievance committee.

11. **It is recommended that the Company revise its WI 1st Level Admin Denial Letter and WI 1st Level Clinical Denial disposition letter to not require that the grievant request a hearing in order**

for the grievance to proceed to the 2nd Level Appeal and be heard by the grievance committee as required by§ Ins. 18.03, Wis. Adm. Code.

Company Response:

The Company agrees with the recommendation and will revise its grievance letters to reflect the new procedures developed as discussed in response to recommendation #10.

12. **It is recommended that the Company improve its existing procedures and provide staff training to better ensure the prompt handling of grievances in compliance with the time frames required by § Ins. 18.03(6) Wis. Adm. Code.**

Company Response:

The Company agrees with the recommendation. Training with respect to Wisconsin-specific requirements was conducted with NASC staff in Duluth in September and December 2003. Compliance staff also provides ongoing consultation to complaint-handling staff. The Company expects to have periodic training sessions, as needed. Also, Wisconsin-specific requirements are included in the NASC training processes. Grids with all state requirements are available to each processor.

Additionally, supervisors pull daily case reports to check compliance. Processors are monitored for compliance with requirements. Managers take action when a processor is deficient, ranging from additional training to termination. The quality program requires review of a sample of files across all states for inclusion of correct state requirements.

13. **It is recommended that the Company improve its existing procedures to ensure that all documentation related to a grievance is maintained in the grievance file for a period of 3 years as required by§ Ins. 18.06(1) Wis. Adm. Code.**

Company Response:

The Company agrees with the recommendation and is developing a new file content policy. The quality program also monitors completeness of files. Finally, NASC images all files and links them to their database, so they can pull up the file at any time.

14. **It is recommended that the Company amend its provider agreements to include a provision that requires the contracting entity to promptly respond to complaints and grievances filed with the Company to facilitate resolution as required by§ Ins. 18.03(2)(c) a. Wis. Adm. Code.**

Company Response:

The Company agrees with the recommendation. The Company filed new provider agreements that include a regulatory addendum for Wisconsin-specific requirements during 2002. The regulatory addendum has a provision for the Company to respond promptly to complaints and grievances. These agreements had not been fully implemented at the time of the audit. The Company has re-contracted with many of the providers. The Company will distribute the updated regulatory addendum to all remaining providers who are not yet contracted using the current agreements. The remaining physicians are expected to be re-contracted by December 31, 2004.

15. **It is recommended that the Company submit to OCI documentation that all members who had received an adverse determination or an experimental treatment determination on or after December 1, 2000 and prior to June 15, 2002, and who had completed the HMO's internal grievance process were provided with a notice that they had the right to request an independent review, as required by§ Ins. 18.11(2)(a) Wis. Adm. Code.**

Company Response:

The Company agrees with the recommendation. The examiners acknowledged that the Company did provide the notice of the right to request an independent review. However, we did not provide to the examiners the criteria used to determine which grievances involved adverse determinations or experimental treatments. We will provide the examiners with the information.

16. **It is recommended that the Company modify the external review provisions in its policy to include an explanation of how to obtain a current listing of IROs, as required by § 632.835(2)(bg) 1 Wis. Adm. Code.**

Company Response:

The Company agrees with the recommendation and has put a process in place to attach the list of IROs from the Wisconsin OCI website to the letters that uphold a grievance and are eligible for external review.

17. **It is recommended that the Company develop and implement procedures to ensure that its customer service staff provides its members with complete information on the independent review process as required by s. 632.835(2) (bg) 1 Wis. Stat.**

Company Response:

The Company agrees with the recommendations. We have adjusted the appeals letters to provide additional instruction for the enrollee to obtain access to an independent review. The service organization will develop and implement all necessary procedures and training to provide IRO information required by § 632.835(2).

18. **It is recommended that the Company develop and implement a procedure that ensures that it accepts independent review requests without requiring a written release from the member in compliance with § Ins. 18.11(3)(b) Wis. Adm. Code.**

Company Response:

The Company does not engage in this practice, however, we acknowledge that the procedures did not reflect specific language to indicate this. The Company has updated the procedure.

19. **It is recommended that the Company develop and implement a procedure whereby a member may request and obtain an independent review of an adverse determination, as defined by § Ins 18.10(1) Wis. Adm. Code or an experimental treatment determination, as defined by § 18.10(2) Wis. Adm. Code.**

Company Response:

The Company agrees with the recommendation. The Company uses terminology to describe all applicable situations as a clinical case review. This includes experimental treatment determinations and other situations that meet the definition of an adverse determination, if any. The procedures allow a member to request and obtain an independent review for these situations. The Company will modify our policy and procedure document to be more specific.

20. **It is recommended that the Company develop and implement a procedure for handling expedited independent review requests that complies with § 632.835(3)(g) Wis. Stat.**

Company Response:

The Company agrees with the recommendation. State specific requirements are included in a grid that accompanies the policies and procedures. This grid will be updated to reflect the correct requirements.

21. **It is recommended that the Company develop and implement a procedure to submit the additional information requested by an IRO or an explanation within 5 business days after receiving a request, as required by § 632.835(g3)(c) Wis. Stat.**

Company Response:

The Company agrees with the recommendation and has updated the grid that accompanies the policy and procedure to reflect the correct requirement.

Small Employer Health Insurance

22. **It is recommended that the Company revise the termination letters used in cases where a small employer group has fallen below the minimum participation requirements of the policy and specifically offer to continue the coverage for 60 days after the non-renewal or termination date to allow the small employer to increase the number of eligible employees to the required number as required by § Ins. 8.54 (4)(a) 2 Wis. Adm. Code.**

Company Response:

The Company agrees with the recommendation and has revised the termination letters to the employer to meet the requirement of the statute.

23. **It is recommended that the Company revise its procedures to record the date it receives a request for a small employer health plan price quote.**

Company Response:

The Company agrees with the recommendation and is developing a mechanism to record the date it receives a request for a small employer health plan price quote.

24. **It is again recommended that the Company establish procedures to ensure that a separate written notice is provided to the policyholder, upon issuance of the policy, which discloses to the policyholder, that the protections afforded by ch. 635 Wis. Stat. will cease to apply and the policy terminated if the employer moves his business outside the state or if the employer no longer meets the definition of small employer, as required by § Ins 8.44 (2) Wis. Adm. Code.**

Company Response:

The Company agrees to provide a separate written notice even though the regulation cited requires only that the Company notify each employer when a policy is issued. The Company already includes the required language in the policy issued to each small group employer.

25. **It is recommended that the Company revise its procedure, Adding Newborns (COSMOS Adding Newborns_tt 9/28/00) to specify and comply with the requirements of § 632.895(5) Wis. Stat.**

Company Response:

The Company agrees with the recommendation. The "Adding Newborn Coverage" policy and procedure, dated November 6, 2003, specifically refers to the Eligibility DIV Specific Detail policy and procedure. This procedure was updated to reflect the Wisconsin timeframes for providing Newborn coverage.

Privacy and Confidentiality

26. **It is recommended that the Company include as a revision to its applications the ability to date the form and limits the length of time the authorization is valid to the policy term or the pendency of a claim for benefits in order to comply with § 610.70(2)(a) 2 and (b) 2 Wis. Stat.**

Company Response:

The Company agrees with the recommendation and has revised its application form.

27. **It is recommended that the Company develop and implement a process for providing to individuals access to recorded personal medical information in order to document compliance with § 610.70(3) Wis. Stat.**

Company Response:

The Company agrees that the information provided during the audit did not completely explain our process for providing access to medical information, nor did it specifically identify Wisconsin code sections. The Company has always had a process in place for an individual to request their recorded personal medical information. With the implementation of the federal privacy regulation in April 2003, we enhanced our processes in order to meet federal and state laws. The process allows the individual or their representative to receive a copy of designated records, account for disclosures made regarding the individuals' records, and provide notice of the individual's right to amend their records. We have since provided the documentation that represents the procedural information and the Wisconsin requirements that are more stringent than the federal privacy regulation.

Managed Care

28. **It is recommended that the Company draft summaries of its quality assurance plan for inclusion in its marketing materials and certificate of coverage or enrollment materials and submit the summaries to OCI with 60 days of the adoption of the examination report in order to comply with§ Ins 9.40 (7)(a) and (b) Wis. Adm. Code.**

Company Response:

The Company agrees with the recommendation. The Company will draft a summary of the quality assurance plan and include it in the pre-enrollment marketing materials. Furthermore, the Company already provides this information to existing members annually in a special mailing.

29. **It is again recommended that the Company amend its provider agreements to include a provision addressing reimbursement for services provided in continuity of care situations, as required by § 609.24(1)(e) Wis. Stat.**

Company Response:

The Company agrees with the recommendation. The Company had amended and filed new provider agreements during 2002. The current version of the regulatory addendum to the provider agreement does include a provision addressing continuity of care situations. The Company began contracting new physicians with the new simplified agreements on January 1, 2003. We are in the process of re-contracting all existing physicians with these simplified agreements with anticipated completion by December 31, 2004.

30. **It is recommended that the Company amend its provider contracts to include a provision regarding the responsibility of the provider specialist to post in – office notice of termination, as required by § Ins. 9.35 (1)(a) 3 Wis. Adm. Code as § 609.24 Wis. Stat.**

Company Response:

The Company agrees with the recommendation. The regulatory addenda to the provider agreements will be updated.

31. **It is recommended that the Company improve its compliance program, including documenting its oversight of its contractors, providers, and vendors in order to meets the requirements of § Ins 9.42 Wis. Adm. Code.**

Company Response:

The Company agrees with the recommendation and will improve our documentation of the oversight process consistent with requirements of § Ins 9.42 Wis.Adm. Code.

Electronic Commerce

32. **It is recommended that the Company develop and implement a process for identifying Company advertisements on the Internet, and for monitoring agent websites to ensure that all advertisements used by agents are approved by the Company, are included in the Company's advertising file, and are compliant with § Ins. 3.27 Wis. Adm. Code.**

Company Response:

The Company agrees with the recommendation and is developing a procedure to periodically review agent websites on the Internet.

Company Operations and Management

33. **It is recommended that the Company improve existing procedures to ensure that current copies of active provider agreements are maintained in order to comply with § 601.42 Wis. Stat.**

Company Response:

The Company agrees with the recommendation and has implemented a procedure to maintain comprehensive files for provider agreements.

34. **It is recommended that the Company operate a process to ensure that it makes periodic and necessary amendments to provider agreements for Wisconsin providers as required by Wisconsin insurance law.**

Company Response:

The Company agrees with the recommendation and had an established process for updating provider agreements at the time of the audit. The Company had amended and filed new provider agreements during 2002, but had not fully implemented these updated agreements by the time of the audit.

35. **It is recommended that the Company designate a management level person familiar with Wisconsin insurance law to be responsible for oversight of Wisconsin claims, grievances and complaints, and for communicating with OCI.**

Company Response:

The Company agrees with the recommendation. While the Company historically has had multiple individuals in Compliance and business operations who have been responsible for oversight of processes and for communicating with OCI, we have not had a single point of contact that is dedicated as a primary interface for communications and escalation of issues. The Company has designated a management level person to assume this responsibility.

State of Wisconsin / OFFICE OF THE COMMISSIONER OF INSURANCE

Jim Doyle, Governor
Jorge Gomez, Commissioner

Wisconsin.gov

125 South Webster • P.O. Box 7873
Madison, Wisconsin 53707-7873
Phone: (608) 266-3585 • Fax: (608) 266-9935
E-Mail: information@oci.state.wi.us
Web Address: oci.wi.gov

Notice of Adoption and Filing of Examination Report

Take notice that the proposed report of the market conduct examination of the

UnitedHealthCare of Wisconsin, Inc.
10701 West Research Drive
Wauwatosa, WI 53226

dated March 24 - June 24, 2003, and served upon the company on March 11, 2004, has been adopted as the final report, and has been placed on file as an official public record of this Office.

Dated at Madison, Wisconsin, this 15th day of April, 2004.

Jorge Gomez
Commissioner of Insurance

STATE OF WISCONSIN

OFFICE OF THE COMMISSIONER OF INSURANCE

MARKET CONDUCT EXAMINATION

OF

UNITEDHEALTHCARE OF WISCONSIN INC.

MARCH 24 – JUNE 24, 2003

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Jim Doyle, Governor
Jorge Gomez, Commissioner

WisconsIn.gov

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Madison, Wisconsin 53707-7873
(608) 266-3585 • (800) 236-8517
Fax: (608) 264-8115
E-Mail: marketreg@oci.state.wi.us
Web Address: oci.wi.gov

June 24, 2003

Honorable Jorge Gomez
Commissioner of Insurance
Madison, WI 53702

Commissioner:

Pursuant to your instructions and authorization, a targeted market conduct examination was conducted March 24, 2003, to June 30, 2003 of:

UNITEDHEALTHCARE OF WISCONSIN INC.
Wauwatosa, Wisconsin

and the following report of the examination is respectfully submitted.

I. INTRODUCTION

UnitedHealthcare of Wisconsin, Inc. (UHCW), can be described as a for-profit, network model health maintenance organization (HMO) insurer. An HMO insurer is defined by s. 609.01 (2), Wis. Stat., as "a health care plan offered by an organization established under ch. 185, 611, 613, or 614, Wis. Stat., or issued a certificate of authority under ch. 618, Wis. Stat., that makes available to its enrolled participants, in consideration for predetermined fixed payments, comprehensive health care services performed by providers selected by the organization." Under the network model, the HMO insurer provides care through contracts with clinics and otherwise independent physicians operating out of their separate offices.

UHCW was incorporated on May 8, 1986, and commenced business on June 6, 1986, as the Heritage Health Plan of Wisconsin, Inc. Simultaneously, the company acquired all of the assets, and assumed all of the liabilities of the PrimeCare Health Plan of Wisconsin, pursuant to an asset purchase agreement dated May 8, 1986. By shareholder

consent dated May 11, 1987, the name of the company was changed to PrimeCare Health Plan, Inc. On March 1, 1990, UnitedHealth Care Corporation (United), a Minnesota managed care holding company, acquired Heritage Holding Company, Inc. (HHC), through purchase of all outstanding shares of common stock on March 1, 1990. HHC, which owned 100% of the company's outstanding common stock at the time of the purchase, was subsequently dissolved, and the ownership interest in the company was transferred to UHC Management Company (UMC). UMC is a wholly owned subsidiary of United. UMC subsequently changed its name to United HealthCare Services (UHS). On August 1, 1991, the company merged with an affiliate, Samaritan Health Plan, which was also a wholly owned subsidiary of UMC. Samaritan, which was the surviving corporation, changed its name to PrimeCare Health Plan, Inc., pursuant to the merger. On July 17, 1996, the company merged with an affiliate, MetraHealth Care Plan of Wisconsin, Inc. PrimeCare Health Plan, Inc., was the surviving corporation. On June 30, 2000, the company became a wholly owned subsidiary of UnitedHealthcare, Inc. (UHC), pursuant to a transfer of 100% of the company's outstanding shares to UHC by UHS. UHC is a Delaware corporation and wholly owned subsidiary of UHS designed to be the holding company for all of the companies that are part of the UnitedHealth Group. UnitedHealth Group Incorporated (United) is the ultimate controlling entity in the insurance holding company system.

On October 9, 1999, the company's board of directors amended the articles of incorporation to change the corporate name to its current name, UnitedHealthcare of Wisconsin, Inc. (UHCW). The name change was effective December 31, 1999.

At the time of the examination, UHCW's service area included the counties of: Dodge, Jefferson, Kenosha, Milwaukee, Ozaukee, Racine, Sheboygan, Walworth, Washington, and Waukesha. UHCW has no employees. Necessary staff is provided through a management agreement with UnitedHealthCare Services, Inc. (UHS). Under the agreement, effective January 1, 2001, UHS agreed to negotiate employer, provider, subscriber, and other contracts;

advise the board; maintain accounting and financial records, recruit marketing, utilization review, and claims processing personnel; and provide or contract for claims processing and management information services.

During 2001 UHG moved UHCW's various operational functions to locations outside Wisconsin. Member and provider service functions were moved to call centers located in St. Louis Missouri, claims intake and administration was moved to San Antonio, Texas and Minneapolis, Minnesota, billing and enrollment functions were moved to Duluth, Minnesota, appeals and grievance functions were moved to Dayton, Ohio. Operational functions related to sales, marketing and provider contracting remained at the company's office in Wauwatosa, Wisconsin.

The majority of the premium written by UHCW in 2001 and 2002 was in group accident and health. The company ranked as the largest writers of group accident and health in both 2001 and 2002.

The following tables summarize the premiums earned in Wisconsin for 2001 and 2002 broken down by line of business.

Wisconsin Premium Summary

2001		
Line of Business	**Direct Premiums Earned**	**% of Total Premium**
Group Comprehensive	$467,304,199	70%
Medicare Supplement	98,672,362	13%
Title XIX Medicaid	101,070,403	17%
Total	$667,046,964	100%

	2002	
Line of Business	Direct Premiums Earned	% of Total Premium
Group Comprehensive	$559,337,125	78%
Medicare Supplement	31,390,964	4%
Title XIX Medicaid	128,718,181	18%
Total	$719,446,270	100%

Complaints

The Office of the Commissioner of Insurance (OCI) received 419 complaints against the HMO between January 1, 2001 through December 3, 2002. A complaint is defined as "a written communication received by the Commissioner's Office that indicates dissatisfaction with an insurance company or agent." The company ranked 23rd on the 2002 complaint summary for group accident and health insurance, with a complaint ratio of .06 compared to a Wisconsin average of .04 complaints per $1,000,000 written premium. The company was not ranked on the complaint summary for 2001, and had a complaint ratio of .02 compared to a Wisconsin average of .05 complaints per $100,000 written premium. The majority of the company's complaints for 2001 and 2002 involved claim administration.

OCI complaint data indicates a significant increase in the number of complaints filed during 2002 and continuing into 2003. This increase in complaints corresponds with the transfer of UHCW's claim and complaint functions to UHG business units. OCI complaint files document a parallel decrease in timely response to OCI complaints, and a decrease in the quality of the company's response.

The following table categorizes the complaints received against the company by type of policy and complaint reason. There may be more than one type of coverage and/or reason for each complaint.

Complaints Received

2002	Reason Type				
Coverage Type	Underwriting	Marketing & Sales	Claims	Policyholder Service	Other
Health	-	-	-	-	-
Individual A&H	-	-	-	-	-
Group A&H	-	-	-	-	-
Credit A&H	-	-	-	-	-
HMO	2	3	173	10	58
PPO	-	-	-	-	-
LSHO	-	-	-	-	-
All Others	-	-	23	3	13
Total	2	3	196	13	71

2001	Reason Type				
Coverage Type	Underwriting	Marketing & Sales	Claims	Policyholder Service	Other
Health	-	-	-	-	-
Individual A&H	-	-	-	-	-
Group A&H	-	-	-	-	-
Credit A&H	-	-	-	-	-
HMO	-	-	84	4	17
PPO	-	-	-	-	-
LSHO	-	-	-	-	-
All Others	-	-	20	1	8
Total	-	-	104	5	25

Grievances

UHCW submitted annual grievance summary reports to OCI for 2001 and 2002, as required by s. Ins 18.06, Wis. Adm. Code. A grievance is defined "as any dissatisfaction with the provision of services or claims practices of an insurer offering a health benefit plan or administration of a health benefit plan by the insurer that is expressed writing to the insurer by, or on behalf of, an insured."

UHCW's grievance report for 2001 indicated that the company received 534 grievances, 172 or 32% were reversed. The majority of the grievances filed with the company in 2001 were related to noncovered benefits. The company's grievance report for 2002

indicated that the company received 1239 grievances. The majority of the grievances filed with the company in 2002 were related to noncovered benefits.

The following tables summarize the grievances for the company for the 2002 and 2001:

2002

Category	No.
Access to Care	0
Continuity of Care	0
Drug & Drug Formulary	65
Emergency Services	36
Experimental Treatment	19
Prior Authorization	383
Noncovered Benefit	404
Not Medically Necessary	28
Other	104
Plan Administration	200
Plan Providers	0
Request for Referral	0
Total	1,239

2001

Category	No.	No. Reversed	% Reversed
Access to Care	1	0	0
Continuity of Care	0	0	0
Drug & Drug Formulary	34	20	59
Emergency Services	6	4	66
Experimental Treatment	6	0	0
Prior Authorization	13	6	46
Noncovered Benefit	251	12	5
Not Medically Necessary	0	0	0
Other	207	123	59
Plan Administration	15	6	40
Plan Providers	0	0	0
Request for Referral	1	1	100
Total	534	172	32%

II. PURPOSE AND SCOPE

A targeted desk audit examination was conducted to determine whether the company's practices and procedures comply with the Wisconsin insurance statutes and rules. The examination focused on the period from January 1, 2001 through December 31,2002. In addition, the examination included a review of any subsequent events deemed important by the examiner-in-charge during the examination.

The scope of the examination was limited to a review of the company's operations in the areas of claims, policyholder services complaints, provider agreements, grievances, small employer health insurance, privacy, electronic commerce and managed care. The examination included a review of compliance with the market conduct examination recommendations in the December 1996 financial examination report and the managed care desk audit dated August 1999.

The report is prepared on an exception basis and comments on those areas of the company's operations where adverse findings were noted.

III. PRIOR EXAMINATION RECOMMENDATIONS

The previous market conduct examination of the company, as adopted May 27, 1998, contained eight recommendations. Following are the recommendations and the examiners' findings regarding the company's compliance with each recommendation:

Small Employer Health Insurance

1. It is recommended that PrimeCare revise the letter sent with proposals of coverage for the standard plan to clarify that the basic health benefit plan is available to all small employer groups, not just those groups medically declined for coverage under the standard plan, pursuant to s. Ins 8.68 (3), Wis. Adm. Code.

   Action: No longer applicable, statute repealed per 1997 Wisconsin Act 27.

2. It is recommended that PrimeCare revise the rating and renewability form used to satisfy the requirements of s. 635.11, Wis. Stat., and s. Ins 8.48, Wis. Adm. Code, to correctly reference a maximum variance from the midpoint rate of 30 % effective August 15, 1994, pursuant to s. Ins 8.52 (2), Wis. Adm. Code.

   Action: Compliance.

3. It is recommended that PrimeCare establish procedures to ensure that a small employer is provided with, and signs at the point of sale, the disclosure form required by s. 635.11, Wis. Stat., and s. Ins 8.48 (1), Wis. Adm. Code, and retain copies of such form in the employer application file.

   Action: Compliance

4. It is recommended that PrimeCare establish procedures to obtain appropriate documentation to verify that a complete list of employees has been obtained from the small employer as part of the application process, pursuant to the requirements of s. Ins 8.65 (1), Wis. Adm. Code.

   Action: Compliance.

5. It is recommended that PrimeCare establish procedures to ensure that all small employer groups who are declined coverage for medical reasons are sent a declination letter and offered the basic health benefit plan, along with a price quote, general description of the plan, and information on how to apply pursuant to s. Ins 8.68 (6), Wis. Adm. Code.

   Action: No longer applicable, statute repealed per 1997 Wisconsin Act 27.

6. It is recommended that PrimeCare establish procedures to ensure that a separate written notice is provided to the policyholder, upon issuance of the policy, which discloses to the policyholder, that the protections afforded by ch. 635, Wis. Stat., will cease to apply if the employer moves his business outside the state or if the employer no longer meets the definition of small employer, as required by s. Ins 8.44 (2), Wis. Adm. Code.

Action: Non-Compliance.

Grievances and Complaints

7. It is recommended that PrimeCare revise grievance reporting procedures to include the total number of all grievances received pursuant to the requirements of s. 609.15 (1) (c), Wis. Stat., and s. Ins 3.50 (10) (g) 3, Wis. Adm. Code.

Action: Compliance.

Miscellaneous

8. It is recommended that PrimeCare revise its EOB form to comply with the requirements of s. Ins 3.651 (4) (a) 8. b., c., and d, Wis. Adm. Code.

Action: Compliance.

Additionally, OCI performed a desk audit of the HMO in 1999 that was limited to managed care compliance issues and resulted in the following report recommendations as adopted November 11, 1999:

Access

9. It is recommended that PrimeCare develop a plan for ensuring the needs of enrollees who are members of under served populations are met, to ensure compliance with s. 609.22 (8), Wis. Stat.

Action: Compliance.

Continuity of Care:

10. It is recommended that PrimeCare modify its provider agreements to include a provision addressing reimbursement for services provided during continuity of care, as required by s. 609.24 (1) (e), Wis. Stat.

Action: Non-Compliance.

IV. CURRENT EXAMINATION FINDINGS

Claims

The examiners reviewed UHCW's response to OCI's claims interrogatory, and its claim procedure manuals, data storage systems, and internal audit reports. UHCW reported that Uniprise, a subsidiary of UHG, was responsible for claims administration and continuation of coverage issues. Ingenix, another subsidiary of UHG, is responsible for subrogation and fraud issues.

The examiners selected to review a random sample of 100 paid and 100 denied claims processed during the period of review including a sample of 50 claims specific to mental health and 50 claims specific to chiropractic services. The examiners encountered great difficulty in obtaining from UHCW claims data in the format requested and this extended the time needed to complete the examination. Although during the period of review, UHCW transitioned its claim system from Wisconsin to out of state locations thereby requiring a claim system conversion, it is the opinion of the examiners that this should not have impacted the company's ability to provide OCI with the claim data in a timely manner and in the format requested.

The examiners found that UHCW did not have a written procedure specific to the handling of claim and coverage issues related to Wisconsin chiropractic services. The examiners also found that the information provided by UHCW to the examiners was inadequate to verify the company's compliance with the requirements of Wisconsin's chiropractic mandate. The company's form letters were generic letters that were apparently used to deny chiropractic claims involving "pre-service denials" and "1st appeal for pre-service" situations involving "cosmetic" treatment, "unproven" service or treatment and "contract language." The examiners found that UHCW's claim denial letters did not contain all of the required information for Wisconsin chiropractic claims. Section 632.875 (2), Wis. Stat., proscribes the actions an insurer

must take if on the basis of an independent evaluation, an insurer restricts or terminates a patient's coverage for the treatment of a condition or complaint by a chiropractor.

1. **Recommendation:** It is recommended that the company develop a written procedure specific to Wisconsin chiropractic claims for handling of claim and coverage issues related to limiting or terminating chiropractic services as required by s. 632.875, Wis. Stat.

2. **Recommendation:** It is recommended that the company modify the form letters it sends to treating chiropractors and patients regarding Wisconsin chiropractic claims to contain all of the information required by s. 632.875 (2) (a) (b) (c) (d) (e) (f) (g) and (h), Wis. Stat.

The examiners found that UHCW's explanation of benefits (EOB) form did not include a line item for claim adjustment reason (ANSI) codes. The company reported that it did use ANSI codes on claims; however, it discovered a claim system problem that resulted in the codes not being printed on generated EOBs. Section Ins 3.651 (4) (a) 5 f, Wis. Adm. Code, provides that the explanation of benefits form for insureds shall include, at a minimum, each claim adjustment reason code, unless the claims is for a dental procedure. Section Ins 3.651 (2), Wis. Adm. Code, defines claim adjustment reason (ANSI) codes as the claim disposition codes of the American National Standards Institute (ANSI) accredited standards committee X12(ASC X12).

3. **Recommendation:** It is recommended that the company correct the identified system problem so that ANSI codes are printed on generated EOB forms for Wisconsin certificateholders as required by s. Ins 3.651 (4) (a) 5. f, Wis. Adm. Code.

The examiners found that the manner in which UHCW responded to requests from insureds for information related to the specific methodology used by the company, in adjudicating claims indicated that UHCW did not have adequate procedures in place to satisfactorily provide this information. The company reported that enrollees received usual and customary information on EOB statements and that enrollees who dispute a claim could resubmit the claim for review and/or call the customer service number on member ID cards. Section Ins 3.60 (6), Wis. Adm. Code, requires that each insurer shall, upon request, provide

the insured with a description of the insurer's specific methodology including, but not limited to, the source of the data used, and statistical data.

4. **Recommendation:** It is recommended that the company develop a written procedure and corresponding letters to ensure that requests from Wisconsin certificateholders for information related to the specific methodology used by the company in adjudicating claims are answered as required by s. Ins 3.60 (6), Wis. Adm. Code.

Parallel to this examination, OCI was investigating claim issues related to UHCW's coverage of mental health services. The examiners found that effective July 1, 2002, the company implemented a separate plan coinsurance requirement of 50% for in-network mental health services. This does not comply with the coverage provisions for mental health service benefits under s. 632.89, Wis. Stat., which provides that a group insurance policy issued by an insurer shall provide coverage of nervous and mental disorders and alcoholism and other drug abuse problems if the policy provides coverage of inpatient hospital treatment or outpatient treatment or both. The statute also provides that coverage may not be subject to exclusions or limitations, including deductibles and copayments, unless they are generally applicable to other conditions covered under the policy. The examiners referred this matter to OCI legal staff for further analysis, and it will be handled as separate from the examination report.

Policyholder Service & Complaints

The examiners reviewed UHCW's response to OCI's policyholder service and complaints interrogatory, its written policies and procedures for handling complaints, internal audit reports and record keeping system. UHCW reported that UNIPRISE was responsible for handling policyholder services and complaints received by the company. UHCW reported that responsibility for responding to consumer complaints received by OCI against the company were referred to National Appeals Service Center (NASC), a Uniprise entity located in Dayton, Ohio. The examiners requested for review a random sample of 50 complaints UHCW received from Wisconsin insureds, or their representatives. The company was unable to provide the requested sample because it did not maintain a record of complaints by individual states. UHCW reported that complaint information was maintained under the member's identification number and complaint information specific to Wisconsin insureds could not be retrieved. Section Ins 18.06 (1), Wis. Adm. Code, provides that "each record of each complaint and grievance submitted to the insurer shall be kept and retained for a period of at least 3 years. These records shall be maintained at the insurer's home or principal office and shall be available for review during examinations by or on request of the commissioner or office."

5. **Recommendation:** It is recommended that the company revise the manner in which it maintains a record of complaints so that it can retrieve complaint information related to Wisconsin insureds for review by OCI in order to comply with s. Ins 18.06 (1), Wis. Adm. Code.

As part of this examination, the examiners conducted a complaint analysis of all complaints received by OCI during 2002 involving UHCW. The examiners found that OCI experienced numerous problems regarding the quality and timeliness of UHCW's response to OCI complaints. OCI complaint records indicate that UHCW's OCI complaints increased from 132 complaints during 2001 to 285 during 2002. OCI records indicate that it had written and verbal communication, including conference calls with the company regarding the quality and timeliness of UHCW's response to complaints. As a result of these communications, UHCW

made changes to its process for responding to OCI complaints, including redirecting OCI complaints to different UHG business unit locations and reassigning primary contacts. Some of the changes were not successful in addressing OCI concerns.

OCI requires that companies respond to OCI within 20 business days of their receipt of an OCI complaint, and that companies contact the complainant within 10 business days. The examiners found that OCI complaint files involving UHCW indicate OCI was required to recontact UHCW several times for adequate response regarding UHCW's failure to timely respond, failure to address how its handling of claims complied with Wisconsin insurance law, and failure to address its provider concerns. UHCW reported that the policy and procedure implemented by NASC provided that all OCI complaints must be responded to within 10 calendar days of receipt and a copy of the response sent to the complainant. The examiners found that UHCW's reported procedures were not reflected in the company's written complaint handling procedures nor was it evident that UHCW followed its existing procedures in responding to OCI complaints received against UHCW during 2002.

6. **Recommendation:** It is recommended that the company revise its complaint procedures involving the handling of OCI complaints to reflect its stated practice of contacting the complainant within 10 days of receiving the complaint per OCI referral instructions in order to comply with s. 601.42, Wis. Stat.

Grievance and Internal Review

The examiners reviewed UHCW's response to OCI's grievance interrogatory, its written grievance procedures and policies, provider agreements, grievance reports and summaries, and grievance committee meeting minutes. In addition, the examiners reviewed UHCW's independent review organization (IRO) process. UHCW reported that the National Appeals Service Center (NASC), a part of the Uniprise system, was responsible for reviewing and responding to grievances, and reporting grievances data to OCI. NASC is also responsible for UHCW's IRO process.

Grievances

The examiners found that UHCW used the process developed for UHG companies in responding to UHCW grievances. UHCW's routing of consumer appeals standard operating procedure defined a complaint as, "Any written or oral communication by a consumer or authorized representative, broker, employer, or network physician or other provider, of dissatisfaction relating to the products, benefits, coverage, services, operations or policies of a UnitedHealth Group entity." Plan errors or service failures were also considered as complaints. This procedure was written to conform to U.S. Department of Labor guidelines. The definition of complaint did not conform with the definition of a complaint in s. Ins 18.02 (2), Wis. Adm. Code. The definition of a complaint also included "written communications" that should be considered grievances per the definition of a grievance in s. Ins 18.01 (4), Wis. Adm. Code.

7. **Recommendation:** It is recommended that the company revise the definition of complaint in its written procedures to comply with the definition of s. Ins 18.01 (2), Wis. Adm. Code, and to handle as grievances all written communications that meet the definition of a grievance in s. Ins 18. 01 (4), Wis. Adm. Code.

The examiners found that UHCW's definition of grievance was too limited to meet the requirements under Wisconsin insurance law. UHCW's operating definition for appeal (grievance) was, "A written request by a member or authorized representative for the review and/or reconsideration of: 1) an adverse plan determination of all or part of a pre-service

request for provision of health care services or benefits, or 2) denial of payment of a claim for a service that has already been provided." This definition was included in the appeal (grievance) procedures in a document entitled "Members and Participating Providers Inquiry, Complaint and Appeal Definitions" (U:NASC Training\Definition member and provider 9-1--02.doc). The definition was too narrow to comply with the definition of grievance in s. Ins 18.01 (4), Wis. Adm. Code, which provided that a grievance was, "any dissatisfaction with the provision of services or claims practices of an insurer offering a health benefit plan or administration of a health benefit plan by the insurer that is expressed in writing to the insurer by, or on behalf of, an insured."

8. **Recommendation:** It is recommended that the company revise its definition of an appeal (grievance) to comply with the requirements of s. Ins 18.01 (4), Wis. Adm. Code.

The examiners found that the manner in which UHCW handled its quality of care grievances did not meet the requirements of Wisconsin insurance law. UHCW's grievance procedure entitled, "Routing of Consumer Appeals Standard Operating Procedures", indicated that written expressions of dissatisfaction involving quality of care issues were not categorized as grievances. The company reported that it believed that this type of written expression of dissatisfaction more closely met the definition of a complaint under s. Ins 18.01 (2), Wis. Adm. Code, and these items were, therefore, handled as complaints.

9. **Recommendation:** It is recommended that the company revise its procedures to handle as grievances written expressions of dissatisfaction involving quality of care issues as required by s. Ins 18.01 (4), Wis. Adm. Code, and s. Ins 18.03, Wis. Adm. Code.

The examiners found that UHCW had a two tier grievance process that did not meet the requirements of Wisconsin insurance law. The company's two tier grievance process included 1st Level Appeals and 2nd Level Appeals whereby grievances were identified as either "clinical" or "administrative." Clinical appeals were defined as, "any appeal that requires review against medical policy guidelines." These appeals were reviewed by medical personnel. Administrative appeals were defined as, "any appeal that does not require medical review." The

receipt of an initial grievance (appeal) was handled as a 1st Level Appeal, and was categorized as either clinical or administrative and assessed accordingly. If there was not a favorable disposition of the grievance at the 1st Level Appeal, the grievant was notified in writing of the right to request a 2nd Level formal hearing review and the method by which to request the review. If a member requested a hearing, the grievance was scheduled for hearing by the Grievance Committee.

10. **Recommendation:** It is recommended that the company revise its appeal/grievance procedures to schedule all unfavorable 1st Level Appeal grievances for hearing by the grievance committee rather than requiring the grievant to request a 2nd Level formal hearing as required by s. Ins 18.03, Wis. Adm. Code.

The examiners found that UHCW's grievance disposition letters (WI 1st Level Admin Denial and WI 1st Level Clinical Denial) that were sent to a grievant following an unfavorable disposition of 1st Level Appeals were not in compliance with the grievance procedure requirements of s. Ins 18.03, Wis. Adm. Code, because the letters required the grievant to request a 2nd Level Appeal in order for the matter to be heard by the grievance committee. The letters stated in part, "If you are not satisfied with this decision, you or an authorized representative may request an enrollee hearing. Please contact me directly at the number below or write to us at the following address.'

11. **Recommendation:** It is recommended that the company revise its WI 1st Level Admin Denial Letter and WI 1st Level Clinical Denial disposition letter to not require that the grievant request a hearing in order for the grievance to proceed to the 2nd Level Appeal and be heard by the grievance committee as required by s. Ins 18.03, Wis. Adm. Code.

The examiners reviewed a random sample of 50 grievance files. The examiners found that one grievance file did not have an acknowledgement letter as required by s Ins 18.03 (4), Wis. Adm. Code. The examiners found that two grievances were not resolved within 30 days as required by s. Ins 18. 03 (6) (b), Wis. Adm. Code, and an extension letter was not sent to the members as required by s. Ins 18.03 (6), Wis. Adm. Code.

12. **Recommendation:** It is recommended that the company improve its existing procedures and provide staff training to better ensure the prompt handling of grievances in compliance with the time frames required by s. Ins 18.03 (6), Wis. Adm. Code.

The examiners found that three of UHCW's grievance files lacked documentation adequate to verify that the grievances were properly handled within the 30 day time frame required by s. Ins 18.03 (6), Wis. Adm. Code. The company provided additional information and documentation to verify that the three grievances were properly handled within the required 30 day time frame, but documentation of this was not included in the grievance files upon initial review by the examiners. Specifically, one file did not contain notification to the member of a hearing date or any indication that a hearing was held. Additionally, this file did not contain a grievance hearing disposition letter. Two files did not contain acknowledgement letters, hearing date notifications, indication that a hearing was held, or grievance hearing disposition letters to the members.

13. **Recommendation:** It is recommended that the company improve its existing procedures to ensure that all documentation related to a grievance is maintained in the grievance file for a period of 3 years as required by s. Ins 18.06 (1), Wis. Adm. Code.

UWHC reported that following the implementation of the U. S. Department of Labor (DOL) regulations on July 1, 2002, governing ERISA procedures, the company expanded the appeal (grievance) procedures to include requests for reconsideration of benefit or claim determinations made by non-participating providers. The company reported that it believed the federal regulations consider these requests, enrollee appeals (grievances) and require that group health plans process them as such. Prior to July 1, 2002, these requests were handled as provider appeals and not included in the annual grievance experience report submitted to OCI as required by s. Ins 18.06 (2), Wis. Adm. Code.

14. **Recommendation:** It is recommended that the company submit an amended grievance experience report to OCI for 2002 deleting those grievances that were included to comply with federal regulations and that the company revise its grievance reporting procedures so that in future reports grievances will be limited to those items that meet the definition of a grievance in s. Ins 18.01 (4), Wis. Adm. Code, and reported to OCI as required by s 18.06, Wis. Adm. Code.

The examiners reviewed 97 provider agreements and found that the language under section 3.3 of the agreements did not adequately explain provider responsibility for identifying and providing the company with copies of grievances. In August 2002, the company developed an amendment for its physician participating agreements, medical group agreements, and hospital participation agreements entitled "Wisconsin Regulatory Requirement Appendix" (form UHC/PA-08.02WI), which states in 4. Grievances, "You must identify complaints and grievances in a timely manner and forward these complaints and grievances to us in a timely manner." Although this language satisfies the requirements of s. Ins 18.03 (2) (c) a, Wis. Adm. Code, the examiners found that the 97 provider agreements reviewed did not include this amendment. Section Ins 18.03 (2) (c) a, Wis. Adm. Code, requires that an insurer that offers a health benefit plan that is a managed care plan must include in each contract between it and its providers, provider networks, and within each agreement governing the administration of provider services, a provision that requires the contracting entity to promptly respond to complaints and grievances filed with the insurer to facilitate resolution.

15. **Recommendation:** It is recommended that the company amend its provider agreements to include a provision that requires the contracting entity to promptly respond to complaints and grievances filed with the company to facilitate resolution as required by s. Ins 18.03 (2) (c) a., Wis. Adm. Code.

Independent Review Process

The Independent Review Organization (IRO) process required under Wisconsin law became operational on June 15, 2002. It gave individuals who had received an adverse determination or an experimental treatment determination on or after December 1, 2000, and prior to June 15, 2002, a retroactive right to request an independent review.

The examiners reviewed UHCW's informational material provided to its members regarding the IRO process, including the amendment to its group policy, and notices in its denial letters, expedited review procedures and its grievance resolution letter. The examiners also reviewed UHCW's procedures for providing all documentation to an IRO when the company receives a review request. UHCW reported that NASC was responsible for requests for IRO review received from Wisconsin certificateholders, their representatives or providers.

The examiners found that although UHCW did provide notice of the right to request an independent review, the company did not provide to examiners the criteria it used to determine which grievances involved adverse determinations or experimental treatment. Section Ins 18.11 (2) (a), Wis. Adm. Code, required insurers to provide a notice of the right to request an independent review to all members who had received an adverse determination or an experimental treatment determination during this time period and who had completed the company's internal grievance process.

16. **Recommendation:** It is recommended that the company submit to OCI documentation that all members who had received an adverse determination or an experimental treatment determination on or after December 1, 2000, and prior to June 15, 2002, and who had completed the HMO's internal grievance process were provided with a notice that they had the right to request an independent review, as required by s. Ins 18.11 (2) (a), Wis. Adm. Code.

The examiners found that UHCW's external review amendment did not explain how to obtain a current listing of IROs. The examiners also found that UHCW's policy amendment and denial letters referred members to the phone number of the company's customer service department and that IRO information being provided to members by the customer service staff was incomplete. Section 632.835 (2) (bg) 1, Wis. Stat., requires the policy to contain a description of the independent review procedure, including an explanation of the member's rights, how to request the review, the time within which the review must be requested, and how to obtain a current listing of IROs.

17. **Recommendation:** It is recommended that the company modify the external review provisions in its policy to include an explanation of how to obtain a current listing of IROs, as required by s. 632.835 (2) (bg) 1, Wis. Adm. Code.

18. **Recommendation:** It is recommended that the company develop and implement procedures to ensure that its customer service staff provides its members with complete information on the independent review process, as required by s. 632.835 (2) (bg) 1, Wis. Stat.

The examiners found that the notice provided to members in UHCW's grievance resolution letter stated that the request for an independent review should include written authorization to release medical records. Section Ins 18.11 (3) (b), Wis. Adm. Code, requires the company to provide the information required in s. 632.835 (3) (b), Wis. Stats., to the IRO without requiring a written release from the member. UHCW reported that it had updated its letter to delete the request for a written release. However, it did not provide documentation to indicate the date of this change.

19. **Recommendation:** It is recommended that the company develop and implement a procedure that ensures that it accepts independent review requests without requiring a written release from the member in compliance with s. Ins 18.11 (3) (b), Wis. Adm. Code.

The examiners found that UHCW's IRO procedure stated that an external review was a clinical case review performed by an independent review organization (IRO). UHCW reported that it considered a request to be a clinical case if it required an appropriate licensed medical professional to review the request against medical policy guidelines for coverage. Section 632.835 (2) (a), Wis. Stat., requires the company to establish an independent review procedure whereby the member may request and obtain an independent review of an adverse determination or an experimental treatment determination. An adverse determination is defined in s. Ins 18.10 (1), Wis. Adm. Code. An experimental treatment determination is defined in s. Ins 18.10 (2), Wis. Adm. Code. The examiners also found that the HMO's procedures did not include a process that allows a member to request and obtain an independent review whenever the member receives an adverse determination or an experimental treatment determination as defined in s. Ins 18.10, Wis. Adm. Code.

20. **Recommendation:** It is recommended that the company develop and implement a procedure whereby a member may request and obtain an independent review of an adverse determination, as defined by s. Ins 18.10 (1), Wis. Adm. Code, or an experimental treatment determination, as defined by s. 18.10 (2), Wis. Adm. Code.

The examiners found that UHCW did not provide to individuals the criteria it used to determine which grievances involved adverse determinations or experimental treatment determinations. The examiners also found that the UHCW's external review procedures did not include a process for providing the IRO with information in the required time periods when the IRO determined that the review should be expedited. Section 632.835 (3) (g), Wis. Stat., requires an insurer to submit its documentation to the IRO within one day of receiving the request if the IRO determines that the review should be expedited. It also requires the insurer to submit any additional information requested by the IRO within two days of the request.

21. **Recommendation:** It is recommended that the company develop and implement a procedure for handling expedited independent review requests that complies with s. 632.835 (3) (g), Wis. Stat.

The examiners found that the company did not have a procedure to respond to an IRO's request for additional information within five business days. Section 632.835 (3) (c), Wis. Stat., requires the company to submit the requested information or an explanation within five business days of receiving the request.

22. **Recommendation:** It is recommended that the company develop and implement a procedure to submit the additional information requested by an IRO or an explanation within 5 business days after receiving a request, as required by s. 632.835 (3) (c), Wis. Stat.

Small Employer Health Insurance

The examiners reviewed UHCW's response to OCI's small employer interrogatory, its written policies and procedures for small employer group business, rating practices, underwriting standards, applications, waiver forms, and standardized letters. UHCW reported that medical underwriting for new small employer business was performed by the Medical Underwriting Department of UHC in Duluth, Minnesota; rating and renewal for small employer groups was performed by the Small Business Group unit of UHC in Duluth, Minnesota and billing for small employer groups was done by Uniprise Group Services in Duluth, Minnesota.

The examiners found that the letters used by the company to terminate a small employer group for failure to meet the minimum participation requirements of the policy did not offer to continue the small employers coverage for 60 days after the nonrenewal or termination date in order to allow the small employer to increase the number of eligible employees to the required number. The company's responses to the examiner's inquiries were not adequate to verify that the company is complying with the notification and extension of coverage requirements of s. Ins 8.54(4), Wis. Adm. Code. Section Ins 8.54 (4) (a) 2., Wis. Adm. Code, provides that a small employer insurer that intends to nonrenew a policy or terminate a policy under s. 635.07 (1) (d), Wis. Stats., because the number of eligible employees is less than the number required to keep the policy in force shall offer to continue the small employer's coverage for not less than 60 days after the nonrenewal or termination date in order to allow the small employer to increase the number of eligible employees to the required number.

23. **Recommendation:** It is recommended that the company revise the termination letters used in cases where a small employer group has fallen below the minimum participation requirements of the policy and specifically offer to continue the coverage for 60 days after the nonrenewal or termination date to allow the small employer to increase the number of eligible employees to the required number as required by s. Ins 8.54 (4) (a) 2., Wis. Adm. Code.

The examiners reviewed a random sample of 50 small employer quotes. The examiners found that although UHCW maintained records of quote requests by agents and small employers, it did not capture the receipt date of the quote request. UHCW reported that it has a 24 hour turn around time "standard" for issuing quotes.

24. **Recommendation:** It is recommended that the company revise its procedures to record the date it receives a request for a small employer health plan price quote.

The examiners reviewed a random sample of 50 small employer files for business issued during the period of review. Section Ins 8.44 (2), Wis. Adm. Code, requires that insures issue a separate notice when the policy is issued to the small employer advising the policyholder that the protections afforded by ch. 635, Wis. Stat., will cease to apply and the policy will terminate if the employer moves his business outside the state or if the employer no longer meets the definition of a small employer. None of the 50 files contained evidence that such a notice was sent. The company maintained that a separate notice is not necessary, because information to satisfy the disclosure requirement of s. Ins 8.44 (2), Wis. Adm. Code, is in the policy.

25. **Recommendation:** It is again recommended that the company establish procedures to ensure that a separate written notice is provided to the policyholder, upon issuance of the policy, which discloses to the policyholder, that the protections afforded by ch. 635, Wis. Stat., will cease to apply and the policy terminated if the employer moves his business outside the state or if the employer no longer meets the definition of small employer, as required by s. Ins 8.44 (2), Wis. Adm. Code.

The examiners found that UHCW's written procedures did not comply with the requirements of s. 632.895 (5), Wis. Stat., as regards the addition of newborn dependents. The HMO's procedure entitled "Adding Newborns" (Form COSMOS Adding Newborns_tt 9/28/00) stated the procedures used to add newborns when notification is received from claims or medical services, or when the subscriber submits an enrollment form. The procedure required that notification to add a newborn dependent must be made to the company within 60 days of the date of birth and that coverage will be effective the date of birth. Although there are specific

procedures to comply with regulations in states other than Wisconsin, no reference is made to s. 632.895 (5), Wis. Stat., which allows for the addition of newborns without medical underwriting up to one year following the date of birth.

26. **Recommendation:** It is recommended that the company revise its procedure, Adding Newborns (COSMOS Adding Newborns_tt 9/28/00) to specify and comply with the requirements of s. 632.895 (5), Wis. Stat.

Privacy and Confidentiality

Section 610.70, Wis. Stat., regarding medical records privacy, became effective June 1, 1999, and created restrictions on insurers regarding their collection and release of personal medical information that correspond with the federal Health Insurance Portability and Accountability Act (HIPAA) requirements. Chapter Ins 25, Wis. Adm. Code, became effective July 1, 2001, to address the provisions of Gramm Leach Bliley, and is based on the National Association of Insurance Commissioners (NAIC) privacy of consumer financial and health information model regulation.

The examiners reviewed UHCW's response to the privacy of consumer financial and information interrogatory, United Health Group's (UHG) privacy manual draft, UHG's employee consumer privacy training manual, UHG business associate agreement, UHG HIPAA privacy assessment tool, UHG privacy notice, and enrollment and disclosure information. UHCW reported that its parent company, UHG, had established the United Privacy Office to address privacy and HIPAA issues. UHG had a chief privacy officer, who reported to UHG general council, who in turn reported to the UHG board of directors.

The examiners found that UHG had developed a privacy program that applied to the functional areas of the company. The examiners review of privacy was limited to UHG's response to the OCI privacy interrogatory and accompanying documents. The examiners found that UHG had developed a privacy compliance checklist to assist managers to implement controls to meet regulatory compliance. The company reported that it had not been subject to internal or external audits of its privacy program.

The examiners found that UHG had an employee consumer privacy training program. Employees sign course acknowledgement forms. The company did not have formal training for agents, however, the company did produce periodic bulletins for its agents.

UHCW reported that it provided a copy of the UHG privacy notice at enrollment. The company reported that it also mailed the notices to members annually and made available on its website a copy of the notice.

The examiners found that UHCW's enrollment application/change/cancellation request forms (form numbers 590-1152 12/01 and 590-1416 12/01) failed to include in the statement of affirmation and authorization to obtain and disclose information in connection with eligibility for medical coverage section a line for dating the form. Section 610.70 (2) (a) 2, Wis. Stat., regarding disclosure of personal medical information, requires that any form that is used in the connection with an insurance transaction and that authorizes the disclosure of personal medical information about an individual to an insurer shall comply with the requirement that the form is dated. Section 610.70 (2) (b) 2, Wis. Stat., provides that for an authorization under this subsection that will be used for the purpose of obtaining information in connection with a claim for benefits under an insurance policy, the length of time specified par. (a) 7., may not exceed the policy term or the pendency of a claim for benefits under the policy, whichever is longer. The company reported that it is revising all of its applications and is in the process of exhausting the stock of old forms.

27. **Recommendation**: It is recommended that the company include as a revision to its applications the ability to date the form and limits the length of time the authorization is valid to the policy term or the pendency of a claim for benefits in order to comply with s. 610.70 (2) (a) 2 and (b) 2, Wis. Stat.

The examiners found that UHCW did not have in place a process for providing to individuals access to their recorded personal medical information. Section 610.70 (3), Wis. Stat., provides that if, after proper identification, an individual or an authorized representative of an individual submits a written request to an insurer for access to recorded personal medical information that concerns the individual and that is in the insurer's possession, within 30 business days after receiving the request the insurer shall do all of the following:

1. Inform the individual or authorized representative of the nature and substance of the recorded personal medical information in writing or by other means.

2. At the option of the individual or authorized representative, permit the individual or authorized representative to inspect and copy the recorded personal medical information, in person and during the insurer's normal business hours, or provide by mail a copy of the information.

3. Disclosure to the individual or authorized representative the identifies, if recorded, of any persons to whom the insurer has disclosed the recorded personal medical information within 2 years prior to the request.

4. Provide to the individual or authorized representative a summary of the procedures by which the individual or authorized representative may request the correction, amendment or deletion of any recorded personal medical information in the possession of the insurer.

28. **Recommendation:** It is recommended that the company develop and implement a process for providing to individuals access to recorded personal medical information in order to document compliance with s. 610.70 (3), Wis. Stat.

Managed Care

Effective March 1, 2000, the market conduct requirements previously contained in s. Ins. 3.50, Wis. Adm. Code, were incorporated into subchapter III of ch. 9, Wis. Adm. Code. Effective December 1, 2001, s. Ins. 9.33, Wis. Adm. Code, was repealed and recreated as subchapter II of ch. 18, Wis. Adm. Code, titled grievance procedures. The managed care section of this report references cites in the administrative code as currently drafted.

The August 1999 desk audit report of UHCW's managed care activities documented the company's efforts toward compliance with 1997 Wisconsin Act 327, which became effective January 1, 1999. The desk audit involved a review of the company's practices and procedures as they related to provider choice, access standards, continuity of care, and quality assurance. The 1999 desk audit of the company's managed care activities included two recommendations. The examiners found that the company failed to comply with one of the recommendations made in the prior managed care desk audit report.

The examiners reviewed UHCW's response to the managed care interrogatory, its policies and procedures regarding plan administration, quality assurance and improvement, credentialing and recredentialing, enrollee access, continuity of care, compliance program, and patient protection, and provider agreements. UHCW reported that no single entity was responsible for its managed care activities. Rather, the responsibility was shared by various departments and committees within the UHG. UHCW received an excellent accreditation outcome as a result of its review by the National Association of Quality Assurance (NCQA), with an expiration date of February 14, 2005. The examiners documented that UHCW had filed with OCI its certification of managed care plan type as required by s. Ins 9.40 (8), Wis. Stat.

The examiners' review of UHCW quality assurance process included a review of its quality improvement program description, quality assurance plan, quality assurance program evaluations for 2000 and 2001, and minutes of its quality improvement committee. The company's 2002 quality improvement program description August update indicated that the QI

program was being restructured to fit with the corporate QI program. The examiners found that UHCW's responsibilities for assuring and improving customer service had been delegated to UHG's regional customer satisfaction committee, which included in addition to Wisconsin, Missouri, Illinois, and Midlands markets. UHCW's 2002 qualify improvement evaluation indicated that its QI committee activities had been modified, expanded and restructured. The examiners found that UHCW had filed annually with OCI a copy of its quality assurance plan as required by s. Ins 9.40 (2), Wis. Adm. Code.

The examiners found that UHCW did not include a summary of its quality assurance plan in its marketing materials or in its certificate of coverage or enrollment materials. Section Ins 9.40 (7), Wis. Adm. Code, requires that all managed care plans, including HMOs, shall (a) include a summary of its quality assurance plan in its marketing materials. (b) Include a brief summary of its quality assurance plan in its certificate of coverage or enrollment materials.

29. **Recommendation:** It is recommended that the company draft summaries of its quality assurance plan for inclusion in its marketing materials and certificate of coverage or enrollment materials and submit the summaries to OCI with 60 days of the adoption of the examination report in order to comply with s. Ins 9.40 (7) (a) and (b), Wis. Adm. Code.

The examiners' review of UHCW's credentialing and recredentialing activities was limited to a review of UHG credentialing and recredentialing plan for 2002-2003, the company's 2001 credentialing and recredentialing plan, UHG's universal application for providers, provider agreements, and minutes from meetings of the credentialing committee. The examiners found that UHG's credentialing and recredentialing plan for 2002-2003 did not address reports of disciplinary action. Section 609.17, Wis. Stat., provides that every defined network plan shall notify the medical examining board or appropriate affiliated credentialing board attached to the medical examining board of any disciplinary action taken against a participating provider who holds a license or certificate granted by the board or affiliated credentialing board.

The examiners found that UHCW contractually delegated responsibility for the credentialing activities of hospitals and group practice providers. The examiners did not review

credentialing procedures for providers that were contractually delegated to other entities. UHCW's 2002 quality improvement evaluation indicated that 317 physicians were credentialed and 1250 were recredentialed. The 2002 QI evaluation also indicated that 2688 of the company's independent physicians and network practitioners were delegated. The examiners did not conduct a review credentialing of files for providers.

The examiners' review of UHCW's activities regarding enrollee access included a review of its availability policy and procedure, access policy and procedure, access program evaluation, provider network summary, and Geo Access reports. UHCW did not require a referral from a primary physician for members to obtain care from other participating providers. The company used Geo Access software to analyze network and member access. The examiners documented that UHCW had filed with OCI its annual certification of access standards as required by s. 609.22, Wis. Stat., and s. Ins 9.34, Wis. Adm. Code.

The examiners' review of UHCW's activities regarding continuity of care included a review of its continuity of care policy and procedure, and provider agreements. The examiners also reviewed a sample of 97 provider agreements. UHCW developed a Wisconsin Regulatory Requirement Appendix to amend its physician provider agreements, medical group agreements and hospital participation agreements in order to satisfy the continuity of care requirements under Wisconsin insurance law. The company also had a written internal procedures regarding the requirement. However, the examiners found that the sample of provider agreements reviewed did not include the amendment language. Section 609.24, Wis. Stat., requires that a managed care plan provide coverage to an enrollee for the services of a provider, regardless of whether the provider is a participating provider at the time the services are provided, if the managed care plan represented that the provider was, or would be, a participating provider in marketing materials that were provided or available to the enrollee. Section 609.24 (1) (e), Wis. Stat., further requires that the insurer include in its provider contracts provisions addressing reimbursement to providers for services rendered in continuity of care situations.

30. **Recommendation:** It is again recommended that the company amend its provider agreements to include a provision addressing reimbursement for services provided in continuity of care situations, as required by s. 609.24 (1) (e), Wis. Stat.

The examiners found that UHCW's Wisconsin Regulatory Requirement Appendix did not contain a provision regarding provider specialists' responsibility for posting notice regarding termination of the provider agreement. The examiners also found that sample of provider agreements reviewed did not contain a provision to satisfy this requirement. Section Ins 9.35 (1) (a) 3, Wis. Adm. Code, requires that if a terminated provider is a specialist and the managed care plan does not require a referral, the provider's contract with the plan shall comply with the requirements of s. 609.24, Wis. Stat., and requires the provider to post a notification of termination with the plan in the provider's office the greater of 30 days prior to the termination or 15 days following the insurer's receipt of the provider's termination notice.

31. **Recommendation**: It is recommended that the company amend its provider contracts to include a provision regarding the responsibility of the provider specialist to post in-office notice of termination, as required by s. Ins 9.35 (1) (a) 3, Wis. Adm. Code and s. 609.24, Wis. Stat.

The examiners' review of UHCW's activities regarding its compliance program included a review of its response to the managed care interrogatory, including UHG's principles of integrity and compliance guide, and integrity and compliance program. UHCW has an agreement with UHS whereby UHS is responsible for negotiating employer, provider, subscriber, and other contracts; advising the board; maintaining accounting and financial records; recruiting marketing, utilization review, and claims processing personnel; and providing or contracting for claims processing and management information services. UHCW responded to the OCI interrogatory question requesting information regarding the company's compliance program, by providing a copy of UHG's principles of integrity and compliance. The examiners found that this document dealt primarily with the acts of employees, committees and officers, and outlined basic principles for them to follow on the job. UHCW also referenced some activities performed by UHS under the administrative service agreement. UHCW did not

provide documentation that it exercised oversight or review of the activities provided by UHS on its behalf. Therefore, the examiners found that UHCW did not document that the company had in place a compliance program and procedures to verify compliance with the requirements of s. Ins 9, Wis. Adm. Code. Section Ins 9.42 (2), Wis. Adm. Code, provides that all insurers shall establish and operate a compliance program that provides reasonable assurance that the insurer is in compliance with s. 609.22, 609.24, 609.30, 609.32, 609.34, 609.36, and 632.83, Wis. Stats., this subchapter and other applicable sections including, but not limited to s. Ins 9.07; Wis. Stat., that violations are detected and timely corrections are taken. Section Ins 9.42 (3), Wis. Adm. Code, provides that an insurer's compliance program shall include regular internal audits, including regular audits of any contractors or sub-contractors who perform functions relating to compliance with s. 609.22, 609.24, 609.30, 609.32, 609.34, 609.36, and 632.83, Wis. Stat., this subchapter and other applicable sections including but not limited to s. Ins 9.07, Wis. Stat.

32. **Recommendation:** It is recommended that the company improve its compliance program, including documenting its oversight of its contractors, providers and vendors, in order to meet the requirements of s. Ins 9.42, Wis. Adm. Code.

Electronic–Commerce

The examiners reviewed UHCW's response to OCI's electronic commerce interrogatory and UHG's corporate websites. UHCW reported that website development and maintenance is controlled at the corporate level for all UHG companies and affiliates. A team of business and system owners are responsible for site development and maintenance. UHCW did not maintain a website independent of the parent company and affiliates. URL's registered to the parent company include uhc.com, myuhc.com, employerservices.com, unitedhealthcareonline.com, and uhcexpress.com.

UHCW's reported that its agents were allowed to link private business websites to UHG's corporate website. UHCW agent agreements did not specifically reference website communications, but did contain provisions related to the accuracy of any marketing materials used by the agent that are not approved by the company and compliance with applicable laws. The examiners found that UHCW did not have a process for monitoring agent websites in order to determine if agents were advertising company products. Section Ins 3.27, Wis. Adm. Code, establishes minimum standards of and guidelines for conduct in the advertising and sale of insurance that prevent unfair competition among insurers and are conducive to the accurate presentation and description to the insurance buying public of policies of insurance.

33. **Recommendation:** It is recommended that the company develop and implement a process for identifying company advertisements on the Internet, and for monitoring agent websites to ensure that all advertisements used by agents are approved by the company, are included in the company's advertising file, and are compliant with s. Ins 3.27, Wis. Adm. Code.

UHCW internet activity was limited to providing general plan information to agents, brokers, providers, and consumers. UHCW reported that it plans to expand current activities to include direct internet sales.

Company Operations and Management

The examiners reviewed UHCW's response to OCI's company operations and management interrogatory and its provider agreements. UHCW reported that United Health Networks, a subsidiary of UHG, was responsible for the drafting, executing, and maintenance of provider agreements.

UHCW used three primary agreements to contract with providers; direct physician agreements, IPA agreements, and medical group agreements. The examiners requested for review a sample of 100 provider agreements. The company was unable to locate and retrieve three of these provider agreements. Section 601.42, Wis. Stat., requires that information from any books, records, electronic data processing systems, computers or any other information storage system be made available to the commissioner at any reasonable time and in any reasonable manner.

34. **Recommendation:** It is recommended that the company improve existing procedures to ensure that current copies of active provider agreements are maintained in order to comply with s. 601.42, Wis. Stat.

The examiners found that although UHCW had developed an amendment titled Wisconsin Regulatory Requirement Appendix, for its provider agreements in order to meet the grievance and continuity of care requirements under Wisconsin insurance law, none of the 97 provider agreements reviewed included the amendment, and that the company had failed to amend its provider agreements in order to comply with s. 609.24, Wis. Stat., and s. Ins 18.03, Wis. Adm. Code.

35. **Recommendation:** It is recommended that the company operate a process to ensure that it makes periodic and necessary amendments to provider agreements for Wisconsin providers as required by Wisconsin insurance law.

The examiners' review of UHCW's response to OCI interrogatories, functional activities and samples has led to serious concerns regarding the lack of oversight by UHCW's management team during and following the conversion of its functions, procedures and systems

to UHG. The examiners' review of the UHCW's compliance with prior market conduct examination recommendations and review of functional areas of the company found that the conversion of UHCW functions into existing UHG processes failed to consider requirements specific to Wisconsin insureds and resulted in UHCW's abdication of control over its processes upon its absorption into UHG.

The examiners' review of UHCW's claim process indicated that UHG did not include in its claims system a process to ensure Wisconsin claims were processed in compliance with Wisconsin mandated benefits and uniform claim reporting requirements.

The examiners' review of UHCW's complaint process and OCI complaint files indicated that UHCW failed to ensure sufficient oversight of this process, which resulted in delayed and incomplete responses to OCI complaints. Further, it appears that UHCW's parent company failure to institute a process for identifying state specific complaints from policyholders and certificateholders only exacerbated the number, source and category of complaints received by OCI.

The examiners' review of UHCW's grievance process and grievance files indicated the UHCW failed to institute grievance requirements that complied with Wisconsin insurance law.

The examiners' review of UHCW's managed care activities indicated that UHCW did not have in place a compliance plan as required by s. Ins 9.42, Wis. Adm. Code.

36. **Recommendation:** It is recommended that the company designate a management level person familiar with Wisconsin insurance law to be responsible for oversight of Wisconsin claims, grievances and complaints, and for communicating with OCI.

V. CONCLUSION

The examiners found that the HMO was not in compliance with two recommendations made in prior examination reports in the areas of small employer health insurance and provider agreements. In addition to repeating these two recommendations, this examination report contains 34 new recommendations. Fifteen recommendations relate to the company's practices and procedures in handling grievances and administering its IRO process. Recommendations were made in all areas reviewed. The examination findings and the large number of recommendations raised serious concerns that UHG was not adequately familiar with, responsive to nor did it invest adequate resources for Wisconsin state specific requirements in its administration of UHCW's health insurance business when it converted UHCW procedures and functions into UHG's existing processes.

VI. SUMMARY OF RECOMMENDATIONS

Claims

Page 11 1. It is recommended that the company develop a written procedure specific to Wisconsin chiropractic claims for handling of claim and coverage issues related to limiting or terminating chiropractic services as required by s. 632.875, Wis. Stat.

Page 11 2. It is recommended that the company modify the form letters it sends to treating chiropractors and patients regarding Wisconsin chiropractic claims to contain all of the information required by s. 632.875 (2) (a) (b) (c) (d) (e) (f) (g) and (h), Wis. Stat.

Page 11 3. It is recommended that the company correct the identified system problem so that ANSI codes are printed on generated EOB forms for Wisconsin certificateholders as required by s. Ins 3.651 (4) (a) 5. f, Wis. Adm. Code.

Page 12 4. It is recommended that the company develop a written procedure and corresponding letters to ensure that requests from Wisconsin certificateholders for information related to the specific methodology used by the company in adjudicating claims are answered as required by s. Ins 3.60 (6), Wis. Adm. Code.

Policyholder Services and Complaints

Page 13 5. It is recommended that the company revise the manner in which it maintains a record of complaints so that it can retrieve complaint information related to Wisconsin insureds for review by OCI in order to comply with s. Ins 18.06 (1), Wis. Adm. Code.

Page 14 6. It is recommended that the company revise its complaint procedures involving the handling of OCI complaints to reflect its stated practice of contacting the complainant within 10 days of receiving the complaint per OCI referral instructions in order to comply with s. 601.42, Wis. Stat.

Grievances and Internal Review

Page 15 7. It is recommended that the company revise the definition of complaint in its written procedures to comply with the definition of s. Ins 18.01 (2), Wis. Adm. Code and to handle as grievances all written communications that meet the definition of a grievance in s. Ins 18. 01, (4) Wis. Adm. Code.

Page 16 8. It is recommended that the company revise its definition of an appeal (grievance) to comply with the requirements of s. Ins 18.01 (4), Wis. Adm. Code.

Page 16 9. It is recommended that the company revise its procedures to handle as grievances written expressions of dissatisfaction involving quality of care issues as required by s. Ins 18.01 (4) and s. Ins 18.03, Wis. Adm. Code.

Page 17 10. It is recommended that the company revise its appeal/grievance procedures to schedule all unfavorable 1st Level Appeal grievances for hearing by the grievance committee rather than requiring the grievant to request a 2nd Level formal hearing as required by s. Ins 18.03 Wis. Adm. Code.

Page 17 11. It is recommended that the company revise its WI 1st Level Admin Denial Letter and WI 1st Level Clinical Denial disposition letter to not require that the grievant request a hearing in order for the grievance to proceed to the 2nd Level Appeal and be heard by the grievance committee as required by s. Ins 18.03, Wis. Adm. Code.

Page 18 12. It is recommended that the company improve its existing procedures and provide staff training to better ensure the prompt handling of grievances in compliance with the time frames required by s. Ins 18.03 (6), Wis. Adm. Code.

Page 18 13. It is recommended that the company improve its existing procedures to ensure that all documentation related to a grievance is maintained in the grievance file for a period of 3 years as required by s. Ins 18.06 (1), Wis. Adm. Code.

Page 19 14. It is recommended that the company submit an amended grievance experience report to OCI for 2002 deleting those grievances that were included to comply with federal regulations and that the company revise its grievance reporting procedures so that in future reports grievances will be limited to those items that meet the definition of a grievance in s. Ins 18.01 (4), Wis. Adm. Code and reported to OCI as required by s 18.06, Wis. Adm. Code.

Page 19 15. It is recommended that the company amend its provider agreements to include a provision that requires the contracting entity to promptly respond to complaints and grievances filed with the company to facilitate resolution as required by s. Ins 18.03 (2) (c) a. Wis. Adm. Code.

Page 20 16. It is recommended that the company submit to OCI documentation that all members who had received an adverse determination or an experimental treatment determination on or after December 1, 2000 and prior to June 15, 2002, and who had completed the HMO's internal grievance process were provided with a notice that they had the right to request an independent review, as required by s. Ins 18.11 (2) (a), Wis. Adm. Code.

Page 21 17. It is recommended that the company modify the external review provisions in its policy to include an explanation of how to obtain a current listing of IROs, as required by s. 632.835 (2) (bg) 1, Wis. Adm. Code.

Page 21 18. It is recommended that the company develop and implement procedures to ensure that its customer service staff provides its members with complete information on the independent review process, as required by s. 632.835 (2) (bg), 1, Wis. Stat.

Page 21 19. It is recommended that the company develop and implement a procedure that ensures that it accepts independent review requests without requiring a written release from the member in compliance with s. Ins 18.11 (3) (b), Wis. Adm. Code.

Page 22 20. It is recommended that the company develop and implement a procedure whereby a member may request and obtain an independent review of an adverse determination, as defined by s. Ins 18.10 (1), Wis. Adm. Code, or an experimental treatment determination, as defined by s. 18.10 (2), Wis. Adm. Code.

Page 22 21. It is recommended that the company develop and implement a procedure for handling expedited independent review requests that complies with s. 632.835 (3) (g), Wis. Stat.

Small Employer Health Insurance

Page 22 22. It is recommended that the company develop and implement a procedure to submit the additional information requested by an IRO or an explanation within 5 business days after receiving a request, as required by s. 632.835 (3) (c), Wis. Stat.

Page 23 23. It is recommended that the company revise the termination letters used in cases where a small employer group has fallen below the minimum participation requirements of the policy and specifically offer to continue the coverage for 60 days after the nonrenewal or termination date to allow the small employer to increase the number of eligible employees to the required number as required by s. Ins 8.54 (4) (a) 2., Wis. Adm. Code.

Page 24 24. It is recommended that the company revise its procedures to record the date it receives a request for a small employer health plan price quote.

Page 24 25. It is again recommended that the company establish procedures to ensure that a separate written notice is provided to the policyholder, upon issuance of the policy, which discloses to the policyholder, that the protections afforded by ch. 635, Wis. Stat., will cease to apply and the policy terminated if the employer moves his business outside the state or if the employer no longer meets the definition of small employer, as required by s. Ins 8.44 (2), Wis. Adm. Code.

Page 25 26. It is recommended that the company revise its procedure, Adding Newborns (COSMOS Adding Newborns_tt 9/28/00) to specify and comply with the requirements of s. 632.895 (5), Wis. Stat.

Privacy and Confidentiality

Page 27 27. It is recommended that the company include as a revision to its applications the ability to date the form and limits the length of time the authorization is valid to the policy term or the pendency of a claim for benefits in order to comply with s. 610.70 (2) (a) 2 and (b) 2, Wis. Stat.

Page 28 28. It is recommended that the company develop and implement a process for providing to individuals access to recorded personal medical information in order to document compliance with s. 610.70 (3), Wis. Stat.

Managed Care

Page 30 29. It is recommended that the company draft summaries of its quality assurance plan for inclusion in its marketing materials and certificate of coverage or enrollment materials and submit the summaries to OCI with 60 days of the adoption of the examination report in order to comply with s. Ins 9.40 (7) (a) and (b), Wis. Adm. Code.

Page 32 30. It is again recommended that the company amend its provider agreements to include a provision addressing reimbursement for services provided in continuity of care situations, as required by s. 609.24 (1) (e), Wis. Stat.

Page 32 31. It is recommended that the company amend its provider contracts to include a provision regarding the responsibility of the provider specialist to post in-office notice of termination, as required by s. Ins 9.35 (1) (a) 3, Wis. Adm. Code and s. 609.24, Wis. Stat.

Page 33 32. It is recommended that the company improve its compliance program, including documenting its oversight of its contractors, providers and vendors, in order to meet the requirements of s. Ins 9.42, Wis. Adm. Code.

Electronic–Commerce

Page 34 33. It is recommended that the company develop and implement a process for identifying company advertisements on the Internet, and for monitoring agent websites to ensure that all advertisements used by agents are approved by the company, are included in the company's advertising file, and are compliant with s. Ins 3.27, Wis. Adm. Code.

Company Operations and Management

Page 35 34. It is recommended that the company improve existing procedures to ensure that current copies of active provider agreements are maintained in order to comply with s. 601.42, Wis. Stat.

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Page 36 36. It is recommended that the company designate a management level person familiar with Wisconsin insurance law to be responsible for oversight of Wisconsin claims, grievances and complaints, and for communicating with OCI.

VII. ACKNOWLEDGEMENT

The courtesy and cooperation extended to the examiners during the course of the examination by the officers and employees of the company is acknowledged.

In addition, to the undersigned, the following representatives of the Office of the Commissioner of Insurance, state of Wisconsin, participated in the examination.

Stephanie Cook	Insurance Examiner
Ken Hendree	Insurance Examiner
Jamie Key	Insurance Examiner
Ashley Natysin	Insurance Examiner
Jerry Zimmer	Insurance Examiner
Diane Dambach	Section Chief

Respectfully submitted,

Pam Ellefson
Examiner-in-Charge

Report of Independent Registered Public Accounting Firm

To the Board of Directors and Shareholders of UnitedHealth Group Incorporated and Subsidiaries:

We have audited the accompanying consolidated balance sheets of UnitedHealth Group Incorporated and Subsidiaries (the "Company") as of December 31, 2004 and 2003, and the related consolidated statements of operations, changes in shareholders' equity, and cash flows for each of the three years in the period ended December 31, 2004. These consolidated financial statements are the responsibility of the Company's management. Our responsibility is to express an opinion on these financial statements based on our audits.

We conducted our audits in accordance with the standards of the Public Company Accounting Oversight Board (United States). Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free of material misstatement. An audit includes examining, on a test basis, evidence supporting the amounts and disclosures in the financial statements. An audit also includes assessing the accounting principles used and significant estimates made by management, as well as evaluating the overall financial statement presentation. We believe that our audits provide a reasonable basis for our opinion.

In our opinion, such consolidated financial statements present fairly, in all material respects, the financial position of UnitedHealth Group Incorporated and Subsidiaries as of December 31, 2004 and 2003, and the results of their operations and their cash flows for each of the three years in the period ended December 31, 2004, in conformity with accounting principles generally accepted in the United States of America.

We have also audited, in accordance with the standards of the Public Company Accounting Oversight Board (United States), the effectiveness of the Company's internal control over financial reporting as of December 31, 2004, based on the criteria established in *Internal Control—The Integrated Framework* issued by the Committee of Sponsoring Organizations of the Treadway Commission and our report dated February 28, 2005, expressed an unqualified opinion on management's assessment of the effectiveness of the Company's internal control over financial reporting and an unqualified opinion on the effectiveness of the Company's internal control over financial reporting.

/s/ DELOITTE & TOUCHE LLP
Minneapolis, Minnesota
February 28, 2005